

**McLaren Print System Order**

Order No: 87085  
 Order Date: 2024-07-19  
 Order Request Date:  
 User: Brooke Pearson  
 Phone: 2316271370

Ship Location: McLaren Cheboygan- BHU Attn: Brooke Pearson  
 748 South Main St  
 Cheboygan, Mi 49721

Brochures  
 Quantity: 500  
 Paragon Dept No: 30462  
 Dept Name: BHU  
 Company Number:

Order Total Price: 20.50

Item Number: MHCC-641-MNM  
 Item Description: Consent to Receive Psychotropic Medications  
 Revision Date: 08/2023  
 Print: 1 sided black and white  
 Paper: 20# Yellow Text  
 Size: 8.5 x 11  
 Fold:  
 Finish: None  
 Drill: 2 Hole Top  
 Poster:  
 Misc Info: SS, Black, Yellow paper



**748 S Main St, Cheboygan, MI 49721**  
**CONSENT TO RECEIVE PSYCHOTROPIC**  
**MEDICATION(S) BEHAVIORAL HEALTH**

A supplemental handout will be given to the patient and guardian (or appropriate) to further explain the treatment, possible adverse reactions, and special instructions.

NAME OF MEDICATION	DATE AND TIME THIS SUPPLEMENTAL HANDOUT EXPLAINING PURPOSE OF MEDICATION AND POTENTIAL ADVERSE EFFECTS GIVEN TO: PATIENT AND/OR GUARDIAN	PATIENT SIGNATURE OR SUPERVISED GUARDIAN (As required) who acknowledges that the physician or the designated caregiver has provided information regarding adverse effects and any special instructions / nursing orders to take the medication	SIGNATURE OF PHYSICIAN OR REGISTERED NURSE PROVIDER EDUCATION TO RECEIVE AND/OR GUARDIAN

If it is my belief the patient or guardian signing this agreement has the ability to understand the risks and possible benefits of taking the prescribed medication.

PATIENT'S SIGNATURE		DATE	TIME
NAME OF MEDICATION	DATE AND TIME SUPPLEMENTAL HANDOUT GIVEN (SEE ABOVE)	PATIENT SIGNATURE OR SUPERVISED GUARDIAN (SEE ABOVE)	SIGNATURE OF PHYSICIAN OR REGISTERED NURSE PROVIDER EDUCATION

If it is my belief the patient or guardian signing this agreement has the ability to understand the risks and possible benefits of taking the prescribed medication.

PATIENT'S SIGNATURE		DATE	TIME
NAME OF MEDICATION	DATE AND TIME SUPPLEMENTAL HANDOUT GIVEN (SEE ABOVE)	PATIENT SIGNATURE OR SUPERVISED GUARDIAN (SEE ABOVE)	SIGNATURE OF PHYSICIAN OR REGISTERED NURSE PROVIDER EDUCATION

If it is my belief the patient or guardian signing this agreement has the ability to understand the risks and possible benefits of taking the prescribed medication.

PATIENT'S SIGNATURE		DATE	TIME

**Spec Info:**



7209

CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION(S)