McLaren Flint
FLINT, MICHIGAN

CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION(S)

A supplemental handout was to given to this patient and guardian (as appropriate) to further explain the treatment, possible adverse reactions, and special instructions.

NAME OF MEDICATION	DATE AND TIME THE SUPPLEMENTAL HANDOUT DESCRIBING PURPOSE OF MEDICATION AND POTENTIAL ADVERSE EFFECTS GIVEN TO RECIPIENT AND/OR GUARDIAN	PATIENT SIGNATURE OR EMPOWERED GUARDIAN *My signature acknowledges that the physician [or his designee] reviewed the medication's purpose, potential adverse effects and any special instructions. I voluntarily consent to take the medication.*	SIGNATURE OF PHYSICIAN OR REGISTERED NURSE PROVIDING EDUCATION TO RECIPIENT AND/OR GUARDIAN

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.

_____

Physician's Signature **Date** **Time**

CONSENT TO RECEIVE PSYCHOTROPIC MEDICATION(S)

17155 Rev. 9.20.13

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PT.

MR.#/RM.

DR.