Name _____
DOB_____

ANTIPSYCHOTICS MEDICATION CONSENT FORM

☐ **First Generation,** Please specify: _____

☐ **Second Generation,** Please specify: _____

Dr._____ would like to begin/continue this medication to help you with the following problems:

☐ Reduce hearing voices and bizarre thinking
☐ Reduce impulsive and aggressive behavior
☐ Reduce Acute Mania Other, please specify:

All medications have side effects. These side effects vary from person to person. Here are some of the side effects you may feel:

Common:

First Generation	**Second Generation**
Dry mouth	Weight gain
Constipation	Drowsiness
Stiff muscle	Muscle stiffness
Drowsiness	

Rare:

Tardive Dyskinesia (muscle movement e.g. mouth twitching)
Elevated prolactin and liver enzymes, Akathisia (feeling a need to keep moving), Increased glucose

Very rare, but potentially life-threatening:

Neuroleptic malignant syndrome (stiffness and high fevers), Agranulocytosis (very low white blood cells associated with clozapine)

IF YOU EXPERIENCE ANY OF THESE SIDE EFFECTS OR ANY OTHER UNUSUAL FEELINGS, PLEASE TELEPHONE THE OFFICE AT _____. IF THE CONCERN IS SEVERE ENOUGH, PLEASE PROCEED TO AN EMERGENCY ROOM.

We have reviewed the above medication and its possible side effects. We understand that we have the right to refuse medications, but agree to discuss this with our physician first. We also understand that if we have further questions regarding the above medication, we will discuss them with our physician.

_____
Parent/Legal Guardian Date

_____
Signature of Patient Date

_____
Prescribing Physician Date