TREATMENT PLAN & INFORMED CONSENT
FOR PSYCHOTROPIC MEDICATION

- You have the right to be informed about your care and to ask questions.
- You have the right to accept or reject any of your care plan.
- You have the right to end your consent verbally or in writing at any time.
- You have the right to language/interpreting services. **Services requested?** ☐ YES ☐ NO
- You have the right to a copy of this Treatment Plan & Consent. **Copy requested?** ☐ YES ☐ NO

Emergency Treatment: An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others. In certain emergencies, medication may be given to you when it is not possible to get your consent. However, once the emergency has passed, your informed consent is required.

Prescriber will discuss with you the information below:

1. Nature and seriousness of your mental illness. **Diagnosis:** _____
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s), i.e. **Symptoms** _____

3. Reasonable alternative treatments and why provider is recommending this particular treatment. Document alternative, if applicable: _____

4. Commonly known probable side effects that you may experience: _____

5. Possible additional side effects which may happen when taking medication(s) longer than three months:

If taking a typical or atypical anti-psychotic medication, you will be given information about a possible side effect called tardive dyskinesia. It is characterized by involuntary movements of the face, mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.

Provider is prescribing the following psychotropic medication(s) for you:

Medication (name)	Dosage Range (how much)	Frequency (how often)	Duration (how long)	Oral or Injection	
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection

Above information explained to client? ☐ YES ☐ NO

Client: _____
DOB: _____

Optum Public Sector San Diego
Funding for services is provided by the County of San Diego Health & Human Services Agency

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Client Statement

Based on the information I have read, discussed and/or reviewed with my prescribing provider (check one)

☐ I understand and give consent to this treatment plan for psychotropic medication(s) on page one.

☐ I give verbal consent only; unwilling or unable to sign form.

☐ I **do not** consent to take the psychotropic medication(s) listed below.

Please list: _____

_____

_____

Client/Legal Rep./Guardian Signature Date

Prescriber Statement

I have reviewed, discussed and recommend the treatment plan (page 1) for above client and:

☐ Client gives consent to this treatment plan for Psychotropic medications.

☐ Client gives verbal consent, but unwilling or unable to sign.

☐ Client given medication without consent due to emergency.

☐ Client unable to understand risks and benefits, and therefore cannot consent.

☐ Other Comments: _____

_____

_____

_____

Prescriber Signature and License Date

_____

Prescriber Printed Name and License

_____

Witness Signature (if applicable): Date

Notice of Privacy Practices has been provided as required by HIPPA ☐**YES** ☐**NO**

State Guide to Medi-Cal Behavioral Health Services and the grievance/appeal process was provided ☐**YES** ☐**NO**

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