MEDICATION TREATMENT CONSENT FORM

I, _____, am a patient of Ramia Gupta, MD.

My psychiatrist, Ramia Gupta, MD, has informed me that she recommends that I receive the medication _____ for the treatment of my illness. She has informed me of the nature of the treatment and has explained to me the risks of possible side effects including

_____
_____.

She specifically discussed the risk of tardive dyskinesia, which may cause involuntary tic-like movements in the face, tongue, neck, arms, and/or legs. I understand that although my psychiatrist has explained the most common side effects of this medication to me, there may be other side effects, and that I should promptly inform Ramia Gupta, MD, if there are any unexpected changes in my condition. I understand that I may not be compelled to take this medication and that I may decide to stop taking it at any time. This should be discussed with my psychiatrist at all times. I also understand that although Dr.Gupta states that this medication will help me,there is no guarantee as to the results that may be expected.
I understand that Ramia Gupta, MD, checks the Prescription Drug Monitoring Program and can discontinue treatment if any prescription drug misuse is discovered. I consent to Dr. Gupta checking this prescription drug monitoring program.

For Female patients only: Please check one:

At the present time, I am not pregnant or nursing ____

At the present time, I am pregnant _____

At the present time, I am attempting to become pregnant_____

If my situation changes I will immediately notify Ramia Gupta, MD, to discuss risks associated with medications.

On this basis I authorize Ramia Gupta, MD, to administer

_____at such intervals as she deems medically necessary.

Signed_____

Dated_____