MONARCH
HEALTH & WELLNESS

3335 E Indian School Rd.
Suite 150-H
Phoenix, AZ 85018

INFORMED CONSENT FOR PSYCHOTROPIC MEDICATION TREATMENT

Client Name _____ Date of Birth _____

Account Number _____

I have discussed the following information with my prescriber for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects;
- The possible alternatives;
- The possible results of not taking the recommended medication;
- The possibility that my medication dose may need to be adjusted over time, in consultation with my prescriber;
- My right to actively participate in my treatment by discussing medication concerns or questions with my prescriber; and
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan).

I UNDERSTAND THE MEDICATION INFORMATION THAT HAS BEEN PROVIDED TO ME. BY SIGNING BELOW, I AGREE TO THE USE OF EACH MEDICATION.

MEDICATION	TARGET SYMPTOMS TO BE ADDRESSED	HOW DISCUSSED	PERSON/ GUARDIAN INTIIALS	DATE	PRESCRIBER INTIIALS	DATE
		☐ In Person ☐ Telephone ☐ Tele-Medicins ☐ Previously				
		☐ In Person ☐ Telephone ☐ Tele-Medicins ☐ Previously				
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		☐ In Person ☐ Telephone ☐ Tele-Medicins ☐ Previously				
		☐ In Person ☐ Telephone ☐ Tele-Medicins ☐ Previously				

Client/Legal Guardian Signature ______________________________ Date ______________

Printed Name ____

Prescriber Signature ____________________________________ Date ______________