



COUNTY OF HUMBOLDT
Department of Health and Human Services
Behavioral Health Branch
1042—Outpatient Medication Advisement

Client ID _____ Client First Name _____ Client Last Name _____
 Date of Birth _____ Date of Service _____ Staff ID _____

COMPLETE THE APPLICABLE SECTION AND SIGN BELOW:

List of Medications—The following medications were discussed:
 (List all scheduled and PRN medications reviewed)

The patient has been given the following information verbally:

1. The patient’s right to refuse medications.
2. The nature of the mental illness or behavior that is the reason the medication has been ordered.
3. The likelihood of improving or not improving without the medication.
4. Reasonable alternative treatments available.
5. The name, type, range of frequency and amount, method of dispensing the medications, and the probable length of time that the medication will be taken.
6. The probable effects and possible side effects of the medication.
7. In the case of antipsychotic medication, particularly if these medications are taken beyond three months, additional side effects may include persistent involuntary movement of the face, mouth, hands, feet, or any other part of the body where voluntary movement takes place. These symptoms of tardive dyskinesia are potentially irreversible and may appear or persist after medications have been discontinued.

The patient consents to treatment with the above listed medications.

Written information was given on: _____

- Black-Box warning was discussed.
- Two medications of same class are being used.
- This medication is being used off label. This has been discussed with client.
- This medication, _____, is being prescribed at doses higher than the FDA recommends. This has been discussed with client.

In signing this form, I am verifying that the above information has been discussed with me. I am aware that I may refuse medication at any time.

Patient Signature (or legal guardian if applicable): _____ Date: _____

Conservator/Public Guardian Signature (if applicable): _____ Date: _____

M.D. Signature: _____ Date: _____ Time: _____

Witness Signature (Required if telephone consent): _____ Date: _____ Time: _____