CENTER FOR FAMILY SERVICES

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INFORMED CONSENT FOR PSYCHIATRIC MEDICATION

Psychiatrist Instructions:

1. Medication name, dosage, and instructions for use:

2. Medication name, dosage, and instructions for use:

3. Medication name, dosage, and instructions for use:

Psychiatrist's Signature _____ Date _____

Consumer Statement:

I have been advised that the following psychotherapeutic medication(s) have been recommended as a part of my treatment plan. I have received the information association with these drugs including benefits, side effects, when it is likely to take effect, potential risk especially when combined with alcohol or non-prescription drugs, and have been given instructions for when and how much to take. The advantages of taking this medication, as well as alternative forms of treatment, and prognosis have been discussed with me.

I am aware that follow up questions regarding this medication will be answered by the psychiatrist or the medical assistant. I am aware that I have the right to refuse this medication at any time and that I may discontinue its use at anytime. I am responsible for telling the medical assistant or the prescriber if I discontinue taking this medication**.**

- ☐ If new medication, fact sheet given and ***informed consent*** obtained (include parent if client is a child).
- ☐ If new medication, client denies allergies
- ☐ I certify that I have been given the right to refuse medication.
- ☐ I have received a written medication information fact sheet for each medication prescribed to me.
- ☐ I am providing CFFS permission to access my medication history from the SureScripts Network National Database

Print Consumer Name _____

Consumer's Signature _____ Date _____

Parent, Spouse, Guardian Signature _____ Relationship _____

CENTER FOR FAMILY SERVICES
CONTROLLED SUBSTANCE INFORMED CONSENT FORM

I, _____ am currently receiving behavioral health services at Center For Family Services. I have been informed that consumers prescribed certain controlled substances including, but not limited to, benzodiazepine tranquilizers, barbiturate sedatives, and stimulants, can abuse those substances or may allow abuse by others, and have some risk of development of an addictive disorder or suffering a relapse of a prior addiction. I have been informed and agree to observe strict rules pertaining to their use if prescribed, and agree to follow the terms and procedures described in this Informed Consent as consideration for, and as a condition of, the willingness of the prescriber whose signature appears below, to consider prescribing or to continue to prescribe controlled substances to treat my behavioral health needs.

1. I will inform my CFS prescriber of any personal current or past substance use/abuse, or any current or past substance use/abuse of any immediate member of my immediate family.
2. I will provide signed authorizations for release of information to the CFS prescriber for permission to speak with my Primary Care Physician, Pharmacist, and other past/current treatment providers who provide my health care. If I refuse to sign authorizations for release of information to such providers, it is agreed that said CFS prescriber may refuse and/or discontinue prescribing a controlled substance as part of my treatment needs due to safety concerns.
3. I agree that my CFS prescriber has permission to discuss all diagnostic and treatment details with other health care providers, pharmacists, or other professionals who provide my health care regarding my use of controlled substances for purposes of maintaining accountability.
4. I will obtain all controlled substances from only one pharmacy. I have been informed that the CFS prescriber will check the NJ State pharmacy board website to ensure I have not obtained controlled prescriptions from other providers and other pharmacies. Should the need arise to change pharmacies; I will inform the CFS prescriber immediately.
5. I will inform the CFS prescriber of all new medications, medical conditions, and any adverse effects I experience from any of the medications prescribed.
6. I will Inform other health care providers that I am taking the controlled substances as prescribed by my CFS prescriber, and that this signed Informed Consent exists. In the event of an emergency, I will provide the foregoing information to emergency department providers.
7. I will not allow anyone else to have, use, sell, or otherwise have access to any controlled substances prescribed to me by my CFS prescriber. I am aware that the sharing of medications with anyone is forbidden and against the law.
8. I am aware that controlled substances may be hazardous or lethal to a person not tolerant to their effects, especially a child or minor, and I agree to keep all medications out of their reach.
9. I am aware that tampering with a written prescription is a felony; my signature on this Informed Consent is my agreement not to change or tamper with my CFS prescriber's written prescription.
10. I am aware that attempting to obtain a controlled substance under false pretenses is illegal and should that occur with controlled substances prescribed to me by a CFS prescriber, CFS can choose to take legal action against me.
11. I agree not to alter my medication in any way, and will take my mediation whole, not

broken, chewed, crushed, injected, or snorted.

12. I will only take my medication as prescribed to me, and will not exceed the maximum prescribed dose. Any change must be approved by my CFS prescriber.
13. I understand these medications should not be stopped abruptly, as withdrawal syndromes may develop.
14. I will cooperate with urine or serum toxicology screenings requested by my CFS prescriber, as well as random pill counts of medication. Failure to comply may/can result in immediate discharge from all CFS treatment services.
15. Should my CFS prescriber become knowledgeable of the presence of unauthorized and/or illegal substances in screening tests, or self-report of substance use/abuse, a referral for further assessment for substance abuse disorder may occur and/or discharge from CFS treatment services.
16. I have informed my CFS prescriber of all known allergies.
17. I have informed my CFS prescriber of all medications I am currently taking, including prescriptions, over- the-counter remedies, herbal therapies, and supplements, aspirin, and any other recreational drug or alcohol use.
18. I will keep all treatment appointments as scheduled in order to receive medication renewals.
19. Refills will not be given over the phone, after office hours, or during weekends, holidays, or agency closures.
20. I understand that treatment by my CFS prescriber has a goal of improved quality of life and ability to function at home and/or work. Treatment progress will be assessed periodically to determine the benefits of continued therapy and/or prescription of controlled substances and it is the decision of my CFS prescriber as to whether continued mediation usage benefits me. I will agree and comply with all treatments as recommended by my CFS prescriber.
21. I have been explained the risks and potential benefits of these therapies, including, but not limited to, psychological addiction, physical dependence, withdrawal and over dosage.
22. I understand that failure to adhere to these policies and/or failure to comply with my CFS prescriber's treatment plan may result in cessation of all treatment at CFS including, medication as prescribed by my CFS prescriber. In the latter occurrence, I will be offered referral information for further specialty assessment with another community provider.

I, the undersigned consumer, attest that the above was discussed with me, and I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this Informed Consent.

CFS Prescriber Signature _____ Date: _____

Print Prescriber Name: _____

Consumer Signature: _____ Date: _____

Print Consumer Name: _____

Date Revised: 11/2018