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Neuroleptic (Antipsychotic) Medication Consent Form

Patient _____

Date_____

I understand that neuroleptic medications (antipsychotics) may be helpful in treating my medical condition. Clozaril, Risperdal, Zyprexa, Seroquel, Geodon, Abilify, and Invega are examples of newer neuroleptics. Haldol, Prolixin, and Navane are examples of older neuroleptics.

These medicines may help me think more clearly, feel less aggressive and hostile, and may decrease other psychiatric symptoms. Some of them may decrease other psychiatric symptoms. Some of them may help my mood. If I take these medicines regularly, they may keep my symptoms from coming back. The medical staff cannot guarantee how I will respond to these medications.

I have talked with my doctor or nurse practitioner about common side effects with these medications. We have talked about tardive dyskinesia (TD). I have been told TD describes movements of the mouth, jaw, tongue, hands, feet, or body that may be irreversible. I know if happens most often when you take older medicines for a long time, and that it can occur spontaneously even when someone has never taken these medications. The newer neuroleptics can cause it too, but much more rarely than the older medications. Sometimes it appears after medicine is stopped or decreased. I have been advised by my doctor to report any symptoms of TD, or other problems related t taking my medications as soon as possible

My doctor and I have also discussed these medications my cause my blood sugar and/or cholesterol levels to go up. I have been told that while taking these medications I may need to be n-=monitored for these side effects, including blood testing

My doctor and I have talked about different treatments for my symptoms and we agree that neuroleptic medicines may help by illness. I have been told that without this medication my condition may improve very slowly but is likely to get worse.

My doctor will try to answer questions I have about these medications. We will work together if we need to change the dose/change medications/stop medications. I agree to take the medications as prescribed by my doctor for the treatment of my medical condition.

Client Signature_____ Date_____

Substitute Decision Maker_____ Date_____

(If the client cannot fully understand this form or is not of legal age, a parent or legal guardian, or agent named as health care power of attorney may be asked to sign as a substitute decision maker)