

Behavioral Health Services Consent to Treat with Psychoactive Medications

The patient, whose name is at the bottom of the page, is being served at Covenant Health System on _____ Date
and has received a complete explanation of: _____ Name of Medication

The explanation was given to the individual in simple, non-technical language and included:	
1.	The nature of his/her mental and physical condition
2.	The expected beneficial effects of his/her condition as a result of treatment with medication
3.	The probable health and mental health consequences of not taking medication including the occurrence, increase or reoccurrence of symptoms of mental illness
4.	Accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits of the medication and why the physician rejects the alternative treatment
5.	A description of the proposed course of treatment with medication
6.	The fact that side effects of varying degrees of severity are a risk of all medications
7.	The relevant side effects of the medication, including: a. any side effects which are known to frequently occur b. any side effects which the patient may be predisposed c. the nature and possible occurrence of the potentially irreversible symptoms of Tardive Dyskinesia in some patients taking neuroleptic medication in large doses and/or over a long period of time d. the potentially harmful side effects and potential danger to an embryo or fetus and the necessity to use a reliable means to avoid pregnancy
8.	Patient advised to notify staff immediately if any of these side effects occur
9.	Instruction given that the patient/individual may withdraw consent at any time
10.	All questions answered concerning this treatment

I have received the Consent to Treat with Psychoactive Medication Information Sheet, along with oral explanation and printed material which summarizes specific information regarding the psychoactive medication for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication as indicated on this form. I understand that I may withdraw this consent at any time; however, a probate court may decide that I must continue taking the psychoactive medication prescribed by my physician.

Patient Signature

Date

Representative and Relationship to Patient

Date

Physician, P.A., R.Ph. or RN giving explanation

Date

Signature of Treating Physician to confirm explanation given by P.A., R.Ph. or RN
(required within two working days of P.A., R.Ph. or RN giving explanation)

Date

Consent to Treat Involving a Minor

If consent is for treatment of a minor under Section 35.01, Texas Family Code, the following information must be provided:

- a. Name of one or both parents, if known _____
- b. Name of legally authorized representative of person, if appointed _____
- c. Date on which treatment is to begin _____

Withdrawal of Consent to Treat

I formally withdraw my consent for _____
(Name of Psychoactive Medication)

Patient Signature

Date/Time

Witness

Date/Time

COVENANT HEALTH SYSTEM

Lubbock, Texas

**PATIENTS' RIGHTS UNDER THE CONSENT TO
TREATMENT WITH PSYCHOACTIVE MEDICINE**

