Andreas J. Edrich MD FASAM MRO
Family Medicine - Board Certified
Addiction Medicine- Board Certified
Medical Review Officer-Certified

Nicci Kochsmeier PA-C
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Jillian Just PA-C

Heritage Hills

FAMILY MEDICINE | ADDICTION MEDICINE | MENTAL HEALTH
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PSYCHOTROPIC MEDICATIONS CONSENT

Patient's
Initials

_____ The nature of my mental condition and the reasons for prescribing the specific medication(s) have been explained to me in terms I understand.

_____ Alternative treatments and their benefits and disadvantages have been explained to me.

_____ The type of medication, the dosage, the range of frequency, the route of administration (oral/IM), and the anticipated length of treatment have been explained to me.

_____ I understand and accept the possible side effects of the following specific types of psychotropic medications which may include, but are not limited to:

Common to psychotropic medications: dizziness, drowsiness, rigidity of muscles, and tremors

Benzodiazepine: unsteadiness of gait, physical dependence, and after prolonged use, should be withdrawn gradually

Antidepressants (SSRI - serotonin specific re-uptake inhibitors): decreased appetite, diarrhea, headache, insomnia, nausea, and nervousness

Atypical antipsychotic medications: decreased coordination and inflammation of the nasal mucous membrane

We actually cover all the side effects as listed in Epocrates under the heading of common and serious as well as black box warnings while the patient is in the exam room with us.

_____ I understand and accept additional possible side effects that may occur when psychotropic medications are taken for extended periods (over three months) include persistent, involuntary movements of the face, mouth, or extremities (hands/feet). These symptoms are potentially irreversible and may appear after the medications have been discontinued.

_____ I understand that psychotropic medication therapy may include certain lab tests on a regular required basis.

_____ I have informed the doctor of all my known allergies.

_____ I have informed the doctor 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.

_____ I have been advised whether I should avoid drinking alcoholic beverages and consuming any or all of these medications while taking the psychotropic medication(s).

_____ I am aware and accept that no guarantees about the results of the treatment have been made.

_____ I have been advised of the probable consequences of declining recommended or alternative therapies.

_____ The doctor has answered all of my questions regarding this treatment.

I certify that I have read and understand this treatment agreement and that all blanks were filled in prior to my signature.

I authorize and direct _Andreas Edrich MD/ Nicci Kochsmeier PA-C/ Jillian Just PA-C to provide treatment with the following psychotropic
medication(s): _____.

_____ _____
Patient (or guardian) signature Date/Time Relationship to Patient

_____ _____

Print Patient/Legal Representative/Witness Signature Date/Time

I certify that I have explained the nature, purpose, anticipated benefits, material risks, complications, and alternatives to the proposed treatment to the patient or the patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

_____Date/Time___ _____Date/Time_____

Andreas J. Edrich M.D. Allyson "Nicci" Kochsmeier PA-C

copy given to patient _____