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GENERAL CONSENT REGARDING MEDICATIONS

Consent for Treatment with _____
(Name of Medication)

I, _____, consulted with Dr. Catherine McCarthy, who has informed me that she recommends that I/my child, _____, receive the above medication for the treatment of my/my child's illness. Dr. McCarthy has informed me of the nature of the treatment and has explained to me the risks of possible side effects. Dr. McCarthy has also informed me of the risks and benefits of alternatives to this treatment vs. no treatment.

The use of medications is intended to cause a favorable change in mind or body. Medications routinely cause, not only the intended, favorable effect, but also additional effects, which are called side effects. Although sometimes favorable, side effects are usually unfavorable. Most medications side effects are reversible (i.e., stopping the medication will stop the side-effect) and cause no lasting damage. Some medications side effects are irreversible and do cause lasting damage. The use of any medication involves some risk.

I understand that although Dr. McCarthy has explained to me the most common side effects of this treatment there may be other possible side effects, and that I should promptly inform Dr. McCarthy if there are any unexpected changes in my/my child's condition.

I understand that I/my child may not be compelled to take this medication and may request, at any time, that the medication be discontinued. However, I understand and recognize that if I stop the medication I/my child may experience serious side effects, and agree to consult with Dr. McCarthy before making such a decision on how to safely discontinue this medication.

Dr. McCarthy will make treatment recommendations. It is my right and responsibility to accept, reject or request modification of her recommendations. I am free to ask her any questions about the medications. I am free to get a second opinion at any time. I am free to call or write to the manufacturer of the medication to get additional information.

I also understand that although Dr. McCarthy believes that this medication will help me/my child, there is no guarantee as to the results that may be expected. I also understand and consent that I/my child may need periodic diagnostic and/or laboratory testing to monitor the treatment.

I understand that Dr. McCarthy needs to see me/my child at a minimum of every three months in regular visits to monitor medication and response and that if I do not bring myself/my child for follow-up as recommended Dr. McCarthy will not be able to continue to prescribe and monitor medication.

As a result of my understanding of the benefits and risks of the proposed medication, I give consent for me/my child to take the medication as recommended.

_____
Printed Name of Patient

_____ _____ _____
Signature of Patient/Patient Representative | Date | Relationship to Patient