ANTIPSYCHOTICS MEDICATION CONSENT FORM

☐ First Generation, Please specify: __________________________
☐ Second Generation, Please specify: __________________________

Dr. __________ would like to begin/continue this medication to help you with the following problems:

☐ Reduce hearing voices and bizarre thinking
☐ Reduce impulsive and aggressive behavior
☐ Reduce Acute Mania
Other, please specify:

All medications have side effects. These side effects vary from person to person. Here are some of the side effects you may feel:

Common:

<table>
<thead>
<tr>
<th>First Generation</th>
<th>Second Generation</th>
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</thead>
<tbody>
<tr>
<td>Dry mouth</td>
<td>Weight gain</td>
</tr>
<tr>
<td>Constipation</td>
<td>Drowsiness</td>
</tr>
<tr>
<td>Stiff muscle</td>
<td>Muscle stiffness</td>
</tr>
<tr>
<td>Drowsiness</td>
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</tbody>
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Rare:

Tardive Dyskinesia (muscle movement e.g. mouth twitching)
Elevated prolactin and liver enzymes, Akathisia (feeling a need to keep moving), Increased glucose

Very rare, but potentially life-threatening:

Neuroleptic malignant syndrome (stiffness and high fevers), Agranulocytosis (very low white blood cells associated with clozapine)

IF YOU EXPERIENCE ANY OF THESE SIDE EFFECTS OR ANY OTHER UNUSUAL FEELINGS, PLEASE TELEPHONE THE OFFICE AT ___________________. IF THE CONCERN IS SEVERE ENOUGH, PLEASE PROCEED TO AN EMERGENCY ROOM.

We have reviewed the above medication and its possible side effects. We understand that we have the right to refuse medications, but agree to discuss this with our physician first. We also understand that if we have further questions regarding the above medication, we will discuss them with our physician.

________________________________________  
Parent/Legal Guardian                                  Date

________________________________________  
Signature of Patient                                        Date

________________________________________  
Prescribing Physician                                     Date