CONSENT FOR PSYCHIATRIC MEDICATIONS

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FIELD SERVICES
SFN 1153 (3-2025)

Clear Fields

Client Name	Client ID	Date of Birth
Episode	Admission Date	Current Date

I consent for psychiatric medications
☐ Yes ☐ No

I have received the following information from my prescriber for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
- The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
- The possible risks and side effects; including risk of medications to pregnant women and women who are breast feeding;
- The possible alternatives and complementary treatments;
- The possible results of not taking the recommended medications;
- The possibility that the medication does and/or frequency may need to be adjusted over time, in consultation with my prescriber;
- My right to actively participate in treatment by discussing medication concerns or questions with my prescriber;

Medications Prescribed

Signature of Client or Legal Representative	Date