Purpose Psychiatry

Patient/Client Being Treated: ________________________ DOB: __________ Provider: _______________

1. Medications are often recommended for treating psychiatric illnesses. The following symptom(s) I am experiencing is/are the reason(s) my medication(s) is/are recommended for me:

- ☐ Lack of energy or motivation
- ☐ Depressed mood
- ☐ Poor appetite or over eating
- ☐ Difficulty concentrating or easily confused
- ☐ Difficulty sleeping or sleeping too much
- ☐ Anxiety or constant worrying
- ☐ Difficulty coping with stress
- ☐ Irritability or agitation
- ☐ Aggression or hostility
- ☐ Mood swings
- ☐ Rapid thoughts
- ☐ Impulsive behaviors
- ☐ Unwanted thoughts
- ☐ Fixed beliefs
- ☐ Fearful feelings or unrealistic fears
- ☐ Visions or voices others can't see or hear
- ☐ Difficulty organizing thoughts
- ☐ Difficulty communicating well with others
- ☐ Hyperactivity
- ☐ Panic attacks
- ☐ Nightmares or flashbacks
- ☐ Muscle stiffness or spasms
- ☐ Restlessness
- ☐ Other: _______________

Medication Name	Medication Type (Class of Med)	Administered by (Route):	Daily Dose (Range):	Frequency (Range):
	□ Antidepressant □ Anti-Anxiety □ Antipsychotic □ Mood Stabilizer □ Psychostimulant □ Anti-EPSE □ Other (specify):	□ Mouth □ Injection □ Oher (specify):		
	□ Antidepressant □ Anti-Anxiety □ Antipsychotic □ Mood Stabilizer □ Psychostimulant □ Anti-EPSE □ Other (specify):	□ Mouth □ Injection □ Oher (specify):		
	□ Antidepressant □ Anti-Anxiety □ Antipsychotic □ Mood Stabilizer □ Psychostimulant □ Anti-EPSE □ Other (specify):	□ Mouth □ Injection □ Oher (specify):		
	□ Antidepressant □ Anti-Anxiety □ Antipsychotic □ Mood Stabilizer □ Psychostimulant □ Anti-EPSE □ Other (specify):	□ Mouth □ Injection □ Oher (specify):		
	□ Antidepressant □ Anti-Anxiety □ Antipsychotic □ Mood Stabilizer □ Psychostimulant □ Anti-EPSE □ Other (specify):	□ Mouth □ Injection □ Oher (specify):		

2. My need for this medication will be evaluated every visit. It is common to continue taking medications after the symptoms have gone away to prevent the symptoms from coming back. It is estimated that I will be prescribed these medications for at least:

☐ 6 months or longer ☐ 12 months or longer ☐ Other:____________________

3. Additional and alternative treatment options deemed reasonable for my condition include:

☐ Psychotherapy ☐ Group or family therapy ☐ Other medications ☐ Other:_____________

4. Side effects, including probable and possible long-term (more than 3 months) side effects, are listed on the back of this form or provided separately.

5. I have been offered and discussed medication information to my satisfaction and understand the importance of:

- Talking to my prescriber if I wish to stop medications in order to discuss the possible effects from stopping medications,
- Lab tests or other assessments performed at least once a year to monitor my progress and risk of experiencing side effects,
- Talking to my prescriber if I plan to or become pregnant or breast feed as many medications can cause birth defects.

6. I have been offered a copy of this medication consent form and understand I have the right to ask for additional medication information, refuse to take medication(s) and I may withdraw this consent at any time.

Client's/Parent/Guardian Signature:	Relationship to Client:	Date Signed/Consented: / /
Prescriber's Signature:	☐ Psychiatric-Mental Health Nurse Practitioner (PMHNP-BC) ☐ Physician Assistant (PA) ☐ Psychiatrist (MD/DO)	Date Signed/Educated/Consent Obtained: / /
Witness Name: (When Client refuses to sign but agrees to taking medication)	Witness Signature: (When Client refuses to sign but agrees to taking medication)	Date Witnessed: / /

32565 Golden Lantern St. #B479
Dana Point, CA 92629
P: 949.205.7802 / F: 949.205.7804
info@purposepsychiatry.com / www.purposepsychiatry.com

Purpose Psychiatry

This is not a complete list of the possible side effects and risks associated with each medication. Consult a healthcare professional to obtain additional information. Talk to your prescriber about ways to prevent or manage all side effects.

Common Side Effects for All	How to Prevent or Manage Probable Side Effects
Upset Stomach	Take the medication with food unless directed otherwise by your prescriber
Constipation or diarrhea	Drink plenty of water, exercise, and eat foods high in fiber (ex: fruits and veggies, whole grains, oatmeal, and others)
Dry mouth	Drink plenty of water, eat a healthy snack or occasionally suck on a sugar-free candy
Drowsiness/fatigue	Ask your prescriber if it is okay to take your medication(s) at bedtime
Headache	Usually goes away within a few days. Drink water and talk to your prescriber if the headache does not go away

Medication or Class	Probable Side Effects	Possible Long-Term Side Effects (More than 3 months)
☐ Antipsychotics	Muscle spasms, restlessness, weight gain, increase blood sugar or cholesterol Females: Increases a hormone that can lead to missed menstrual cycle or milk production Males: Increases a hormone that can lead to increased fat tissue around breast or decreased desire for sex	Repeated movements of muscles of the face, mouth, arms, legs or torso and may appear after the antipsychotic is stopped
☐ Antidepressants	Temporary jittery feeling when first started or with a dose increase If stopped suddenly: flu-like symptoms, brain zaps or shock-like feelings	Males: delayed ejaculation Females: difficulty having an orgasm
☐ Mood Stabilizers o Valproate derivatives o Carbamazepine o Oxcarbazepine o Lamotrigine	Rash, dizziness, unsteadiness, blurred or double vision, weight gain	Abnormal blood counts or sodium, missed menstrual cycle, hair loss or increased body hair.
☐ Mood Stabilizers o Lithium	Increased thirst and urination, acne, tremor	Lowers thyroid or kidney function
☐ Psychostimulant	Fast heartbeat, anxiety, reduced appetite, weight loss, irritability, trouble falling asleep	Delayed growth, lower sex drive
☐ Sleep, Anti-Anxiety, or Anti-EPSE Agents		
o Benzodiazepine o Nonbenzodiazepine (Z-drug)	Weakness or fatigue, unsteadiness, dizziness, hang over effects, risk of falls, unusual dreams, sleep eating or driving	Memory difficulties, habit forming
o Buspirone	Dizziness, jittery or restless feeling, difficulty sleeping, confusion, blurred vision	Well tolerated
o Gabapentin o Pregabalin	Fatigue, dizziness, blurred vision	Weight change, leg swelling
o Hydroxyzine o Diphenhydramine o Benztropine	Dizziness, fatigue, sleepiness, difficulty concentrating, blurred or double vision, difficulty urinating	Memory difficulties or clouded thoughts
o Propranolol	Fatigue, dizziness, lowers blood pressure and heart rate	Lower blood pressure and heart rate

□ Other Medication	Additional Medication Information Sheets Offered? □ Yes, provided to client □ Yes, client declined	
Medication names:	Probable Side Effects	Possible Long-Term Side Effects (More than 3 months)

Client's/Parent/Guardian Signature: (Acknowledgement of Education Received and Understanding)	Relationship to Client:	Date Signed/Acknowledged: / /
Prescriber's Signature: (Acknowledgment of Education and Explanation Provided)	☐ Psychiatric-Mental Health Nurse Practitioner (PMHNP-BC) ☐ Physician Assistant (PA) ☐ Psychiatrist (MD/DO)	Date Signed/Education Provided / /

32565 Golden Lantern St. #B479
Dana Point, CA 92629
P: 949.205.7802 / F: 949.205.7804
info@purposepsychiatry.com / www.purposepsychiatry.com