



**Behavioral Health Program  
ANTIPSYCHOTIC MEDICATION AGREEMENT FORM**

CLIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

Is the client 18 years old or older?

Yes    No

Medication: \_\_\_\_\_

Type of antipsychotic:

*First Generation*

*Second Generation*

Your psychiatric nurse practitioner would like to begin/continue this medication to help you with the following problems (circle all that apply):

*Reduce hearing voices and bizarre thinking*

*Reduce impulsive and aggressive behaviors*

*Reduce acute mania*

*Other: \_\_\_\_\_*

**Common Side Effects:**

Dry mouth, constipation, stiff muscles, drowsiness, weight gain

**Rare Side Effects:**

Tardive Dyskinesia (unusual 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 SIDE EFFECTS:**

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, then please call the office at 508-679-6833 x100. IF THE CONCERN IS SEVERE ENOUGH, PLEASE PROCEED TO THE NEAREST EMERGENCY ROOM.

**\*\* PLEASE BE ADVISED THAT ABRUPTLY DISCONTINUING SOME OF THESE MEDICATIONS CAN RESULT IN PROBLEMATIC SIDE EFFECTS OR RECURRENCE OF ORIGINAL SYMPTOMS. \*\***



**OFF-LABEL ACKNOWLEDGEMENT:**

*I have been made aware that prescriptions for children and adolescents may be “off-label,” meaning that pharmaceutical companies have not sought FDA approval to market medications for the treatment of youth.*

Initials: \_\_\_\_\_

**TREATMENT ACKNOWLEDGEMENT:**

*I understand that treatment will be monitored by me as well as the provider and that I will communicate with the provider if I have questions or if my child has problems with the medication.*

Initials: \_\_\_\_\_

**SIDE-EFFECT ACKNOWLEDGEMENT:**

*The provider has reviewed the above possible side effects with me, and I understand that I have the right to refuse or discontinue medications but agree to discuss this with our providers first.*

Initials: \_\_\_\_\_

**CONSENT FORM ACKNOWLEDGEMENT:**

*We were provided with a copy of this consent form.*

Initials: \_\_\_\_\_

\_\_\_\_\_  
Client (if over 18 y.o.) or Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Relationship to Client