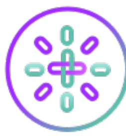

ADIHEALTH

MEDICATION INFORMATION AND CONSENT

A copy of this form must be submitted to the office prior to us ordering your medication. Delays in returning this form WILL result in delays with your prescription.

Patient Name: ______________________________ DOB: ________________________

Parent Name: ______________________________ *(if patient is a minor)*

Pharmacy Information (Required)

Pharmacy Name: ___________________________ Phone: _______________________

Street, City, Zip Code: ____

Prescription Drug Coverage Co: ____________ Prescription Member ID: __________________

I have educated the patient/parent(s) on the risks, benefits, indications, contraindications and side-effects of the following medications. I have also informed the patient/parent(s) of possible consequences of not taking said medications. Parents have been advised to monitor the medications of the youngster for compliance and safety reasons. It has been **STRONGLY ADVISED** that parents dispense the medications to their child and keep them safely locked up when not being used.

Medication & Dosage	Today's Date	Patient's Initials	Parent's Initials
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

__ Off-label use of the medication has been explained to the patient/parent(s)/guardian(s)

__ NIMH handout "Your Child and Medication" has been provided in Onboarding Package

Patient Signature: ________________________________ **Date:** ____________

Parent Signature: ________________________________ **Date:** ____________

ATULA SHARMA, M.D. *Board Certified Child, Adolescent, & Adult Psychiatrist*
MORGAN FALLOR, M.D. *Board Certified Child, Adolescent, & Adult Psychiatrist*

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