

GEORGIA DEPARTMENT OF CORRECTIONS

Facility: \_\_\_\_\_

MENTAL HEALTH SERVICES

Name: \_\_\_\_\_

**Informed Consent for Mental Health Medication**

GDC#: \_\_\_\_\_

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

Race: \_\_\_\_\_ Sex: \_\_\_\_\_

**Tricyclic Antidepressant Informed Consent**

**MEDICATION:**

**ANTICIPATED DOSAGE RANGE:**

**TARGET SYMPTOMS AND BENEFITS:**

Alternative treatments may include other medications, activity and talk therapies.

**SIDE EFFECTS/RISKS OF THIS TREATMENT:** Drowsiness or sleepiness, dry mouth and eyes, constipation, mild tremor, sweating, mild agitation, weakness or headache, ringing in the ears, nausea, poor heat tolerance, loss of weight or appetite. Suddenly stopping this medication may cause medical problems. In rare cases, this class of medications may cause life threatening irregularities in heart beats and, in depressed patients who are less than 24 years old, increased suicidality. Other conditions to watch for are:

**RISKS OF REFUSING THIS TREATMENT** include, but are not limited to: Continuation or worsening of your symptoms and distress (including periods of depressed mood, irritability, loss of interest and enjoyment, and hopelessness), and becoming less able to care for yourself.

**LENGTH OF CARE:** The medication usually begins to act within 2-4 weeks. Reliable benefits require regular, long term usage. Your doctor may adjust the dosage during treatment, in most cases, to the lowest dosage that is needed. Your doctor may order laboratory tests from time to time to make sure that the medication is being given properly and is not causing medical problems.

**NOTIFICATION:** You have the right to stop taking this medication at any time, but we strongly recommend that you talk to your doctor first. If you decide to stop taking the medication, it will not affect your ability to receive other MH services but may affect your ability to remain on your current MH level if you decompensate. Avoid excessive heat or dehydration while taking this medication. For female patients: Let your doctor know if there is a possibility that you are pregnant.

**I understand that by signing this form I am agreeing to be treated with this medication. Mental health staff have given me information about this treatment, including the reasons I am being treated and the information on this form. I have had a chance to ask any questions about my treatment I wished to ask. I understand that I can discuss any other questions I might have about my treatment with the doctor and that a copy of this form will be given to me.**

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Prescribing Practitioner Signature: \_\_\_\_\_  
Name/Title Stamp:

**I have been advised to take this medication, but I am unwilling to take it as prescribed. The risks of not taking this medication have been explained to me.**

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Prescribing Practitioner Signature: \_\_\_\_\_  
Name/Title Stamp: