*** REQUIRED INFORMATION**

☐ I have received written and verbal education concerning my prescribed medication (s), including the indications, directions, interactions, possible side effects, and risk & benefit ratio including alternatives.

Along with the risks of metabolic syndrome, risk of extrapyramidal side effects and tardive dyskinesia (if applicable)

Including heat precautions

Including the risk of Steven Johnson's syndrome with certain medications (if applicable and to stop I the medication immediately if rash occurs). Including the potential risk of birth defects (if applicable).

Including the potential risk of dependency of any stimulants or benzodiazepines (if prescribed or applicable), and not to operate machinery after ingesting a medication that is sedating.

I have been educated not to mix my medication(s) prescribed with alcohol, marijuana, opiates or illegal substances.

I understand and consent to the medication (s) telehealth and face to face treatment plan in place.

PRESCRIBER NAME

DATE

Enter date here

PATIENT NAME *

Enter patient name here

PATIENT SIGNATURE *

DATE

Enter date here

GUARDIAN NAME *

GUARDIAN SIGNATURE *

DATE

Enter patient name here

Enter date here