1730 Walton Road, Suite 205
Blue Bell, PA 19422

www.bluebellpsychiatry.com
email: jamesyi@bbpsychiatry.com
phone: (267) 297-2289
fax: (267) 297-2275

INFORMED CONSENT TO TREAT WITH MEDICATION

I, ____, do hereby authorize James Yi, MD-PhD and any other providers working for (or prescribing for) Blue Bell Psychiatry to prescribe the following medication(s):

Name of Medication(s): ___________________________________ ___________________________________

___________________________________ ___________________________________

I understand that the reason this/these medication(s) are being prescribed is to treat my illness. Furthermore, by signing this **Consent Form** <u>I am confirming that James Yi, MD-PhD has also informed me of the nature of the treatment, the type of medication I am taking and any subsequent risks or side effects associated with this/these medication (s) - and that I understand the risks and side effects associated with this/these medication (s).</u>

Please check and initial one choice below:

______ I am allergic to ____ ______________ Initials

______ I have **NO KNOWN ALLERGIES** to medicines ______________ Initials

Female Patients:

______ **<u>Yes, I am pregnant.</u>** I understand that this/ these medication(s) may harm a developing baby and be passed in breast milk and harm a breast-feed child. ______________ Initials

______ **<u>No, I am not pregnant.</u>** I understand that this/ these medication(s) may harm a developing baby and be passed in breast milk and harm a breast-feed child. ______________ Initials

I understand that I may not be compelled to take this/ these medication(s) and that I may discontinue the medication at anytime. However, I further understand that if I stop taking the medication I may experience serious side effects, and therefore, I should not discontinue the medication without the awareness and active participation of my physician, physician assistant or nurse practitioner.

OFF LABEL MEDICATION: Off- Label medication is defined as: <u>The use of a drug to treat a condition, or target symptom(s), even though the drug is not specifically approved to do so by the US Food and Drug Administration (FDA).</u>

My signature below indicates that:

1. <u>I understand the contents of this release</u> as well as my rights with respect to agreeing to or refusing any medication.
2. This consent form was discussed with me in detail and that all of my questions were answered to my satisfaction.
3. The nature and rationale of treatment with this/these medication (s), explanation of possible side effects (including black box warnings) and whether this/these medication(s) is/are being prescribed for "OFF LABEL" use was also discussed and I have no further questions. Signing indicates that I believe the benefits of treatment outweigh the risks.

____ Date _________________________
Patient

____ Date _________________________
Parent/Guardian (if patient is less than 14 years old)

____ Date _________________________
James Yi, MD-PhD