CONSENT FOR TREATMENT

PATIENT NAME: DOB: DATE:

DIAGNOSIS:

TARGET SYMPTOMS:

TREATMENT PROTOCOL:

ALTERNATIVE TREATMENTS DISCUSSED:

POSSIBLE RESULTS OF NO TREATMENT:

SIDE EFFECTS DISCUSSED:

FDA LABELING DISCUSSED:

CONSENT AND ASSENT DISCUSSED:

COMMENTS/QUESTIONS/CONCERNS:

I UNDERSTAND THIS CONSENT, AND ALL HAS BEEN EXPLAINED TO ME. TREATMENT, INCLUDING USE OF MEDICATIONS IS VOLUNTARY AND I PLAN TO WORK WITH THE DOCTOR TO MAKE THE BEST USE OF THESE.

I CONSENT TO THE TREATMENT.

IF MEDICATION IS PART OF THE TREATMENT PLAN AND I WILL REQUEST THE PRODUCT INFORMATION INSERT AT THE TIME A PRESCRIPTION IS FILLED.

_____ _____ _____

PATIENT SIGNATURE DATE PHYSICIAN

_____ _____

PARENT/GUARDIAN (IF APPLICABLE) RELATIONSHSIP TO PATIENT

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(this is for later if/when we add medications)

update to plan: date initial of responsible party