CALLOWHILL FAMILY THERAPY, PC REQUEST FOR PSYCHIATRIC EVALUATION

DATE:

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NAME:		AGE:	
REFERRED BY {NAME:}	9		
THEF	CAPIST/PHYSICIAN/OTHER		
REASON FOR REQUEST:	ANXIETY	DEPRESSION	
The state of the s	POOR SLEEP	PANIC	
	INABILITY TO F		
CLIENT ACCEPTS THERAPY		REFUSES:	
CLIENT WILLING TO TAKE MEDS: CURRENT MEDICATIONS: {NAMES & DOSAGES		REFUSES:	
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POINTMENT WITH THE DO			
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GNATURE/CLIENT OR GUAR			

. Callowhill Family Therapy, PC 244 North Fifth Street Reading, PA 19601

Phone: 610-372-8822 Fax: 610-372-6626

Consent for treatment with medication

The psychiatrist has informed me that she recommends that I receive medication and therapy for the treatment of my illness. I have been informed of the nature of the treatment, and the risks of possible side effects, potential benefits and alternative forms of treatment.

I understand that I should inform the doctor or office staff if there are any problems, reactions and/or changes in my condition, which may be, related to this medication.

I understand that I do not have to take this medication. My physician believes that this medication is likely to help me but is unable to give me a guarantee of its' effectiveness.

I understand that the information on the patient information leaflet is selective, for use as an educational aid and does not cover all of the possible uses, actions, precautions, side effects or interactions of this medications with other prescribed or over the counter medications. I understand that further information can and should be provided by my pharmacist at the time the prescription is filled. I further understand that this form does not provide specific medical advice for individual medical problems, however, it provides official acknowledgement that I have been provided knowledge of the medications that have been prescribed for me by the psychiatrist.

On this basis, by my signature below, I authorize the psychiatrist or anyone authorized by the psychiatrist to prescribe these medications at such intervals as recommended.

Medication	<u>Date & Initial</u>	ntion was distributed to <u>Medication</u>	Date & Initial	<u>Medication</u>	<u>Date & Initial</u>
Ritalin		Wellbutrin		Tegretol -	
Dexedrine	3	Antiparkinson		Lithium -	
Culert		MAO Inhibitor		Risperdal	
Benzodiazepines		Neuroleptics		Ambien	
Buspar		- Sleep Aids		_ Effexor	
Vistaril/Atarax		SSRI Agents		Others:	
- Tricyclic		- Clorazil			
Desyrel		Depakote/Depakane			
The reason for	the prescribed med local while toking of	Check All T ation(s) were explain dication(s) were expl sychotropic medicatio f the issues regardin	ed and discussed t ained to me. on(s) have been ex	plained to me,	
atient / Guardian	Signature	Date	Psychiatrist	<u> </u>	Date