Pediatric Neurologists of Palm Beach

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PSYCHOTROPICS CONSENT FORM

- I have been informed of my child's medical condition and the reason for prescribing the medications have been explained.
- I understand these medications may be off label use in pediatrics.
- I understand I am responsible for informing my provider of all allergies and medications - Rx and over the counter.
- I was informed of alternative treatments. I will seek Psychiatry/counseling as recommended.
- I will complete ordered lab tests required for this medication.
- I understand that if I have Medicaid, I will sign additional consent with my insurance.
- I certify I am the guardian authorized to make these decisions.
- I accept the risks/SE of the medication I am prescribed including but not limited to:
  - Antidepressants - (SSRI'S Prozac, Zoloft, Paxil)- decreased appetite, insomnia, and bone fracture. **Serotonin syndrome. INCREASED RISK SUICIDE in children. DO NOT ABRUPTLY STOP - must be weaned by Rx provider.**
  - Atypical Antipsychotics - (Risperidone, Seroquel, Abilify) - **tardive dyskinesia - may be permanent after meds stopped**, low blood pressure and metabolic disorders. Increased caution with SSRI, Intuniv/Guanfacine. **DO NOT ABRUPTLY STOP - must be weaned by Rx provider.**
  - Mood stabilizers - (Lamictal) - Stevens-Johnson, life threatening rash. Additional caution when used with Valporate. Stop immediately if rash develops.

I certify that I have read and understand the above and want to proceed with treatment. I authorize and direct my provider to provide the prescribed treatment.

Patient name:_____ Patient DOB:_____

Parent/legal guardian-Print name/SIGN:_____DATE:_____