Medication Informed Consent

Client Name: _____ D.O.B.: _____

I am aware the practice of behavioral healthcare is not an exact science. I consent to the use of prescription medication as a part of my overall treatment and I acknowledge that no guarantees have been made to me as results of treatment and therapy received at Lutheran Family Services, of Nebraska, Inc. (LFS). I understand the decision to take the medication is voluntary. My signature is an acknowledgement that I have had the risks, benefits and alternatives of prescription medications explained to me.

I agree to follow the prescribing practitioner's orders regarding the use of the medication and I agree to report side effects and/or problems with the medication.

I understand if medication is administered by a licensed medical professional in the office, I agree to the benefits and risks of said medication. By verbally agreeing to medication administration, I understand I give my consent for the medication to be administered to me by LFS staff. I understand that I may refuse administration of any medication at any time. Appropriate staff may be notified in the event of my refusal of medication for the benefit of my recovery.

I understand it is my responsibility to monitor when my prescription needs to be refilled. I understand that refills for medications require three (3) business day notices and I understand that refills require preapproval of the medical provider and my active participation and attendance compliance with appointments.

I understand when receiving medications/prescriptions through LFS outside of my face-to-face meeting with my medication provider, whether it is through patient assistance, sampling or another program or a prescription, I must pick up the medication or make prior arrangements for a designated party to pick up the medication/prescription. Any and all designated persons to pick up my medications/prescriptions must have been authorized by me in writing prior to the designee having access. I understand I or the designated party will be required to show proper identification and sign to have the medication/prescription released. I understand that if I do not pick medication within 90 days of being notified or in the event of the medication expiration, the medication will be disposed of by the agency.

I acknowledge written prescription(s) for any controlled substance will only be released to me or my legal guardian.

The undersigned certifies they have read and understand the above statements:

_____ _____

Signature of Client or Parent/Guardian Date

Relationship to Client: _____

_____ _____

Signature of Witness Date