



**AHCCCS MEDICAL POLICY MANUAL**  
**POLICY 310-V, ATTACHMENT A - INFORMED CONSENT/ASSENT FOR**  
**PSYCHOTROPIC MEDICATION TREATMENT**

I have discussed the following information with my Behavioral Health Medical Practitioner (BHMP) or other prescribing clinician for each medication listed below:

- The diagnosis and target symptoms for the medication recommended,
- The possible benefits/intended outcome of the treatment, and as applicable, all available procedures involved in the proposed treatment,
- The possible risks and side effects, including risks of medication to pregnant women and women who are breast feeding,
- The possible alternatives,
- The possible results of not taking the recommended medication,
- The possibility that my medication dose may need to be adjusted over time, in consultation with my behavioral health medical practitioner,
- My right to actively participate in my treatment by discussing medication concerns or questions with my behavioral health medical practitioner,
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan),
- For Members under 18 years of age, the FDA status of the medication and the level of evidence supporting the recommended medication, and,
- For Members under 18 years of age, the youth is encouraged to assent or agree to the medication but the youth's Health Care Decision Maker has the final say in consent for the use of medication unless the youth is emancipated.

**I UNDERSTAND THE MEDICATION INFORMATION THAT HAS BEEN PROVIDED TO ME.**  
**BY SIGNING BELOW, I AGREE TO THE USE OF EACH MEDICATION.**

<b>MEDICATION</b>	<b>HOW WAS MEDICATION INFORMATION DISCUSSED?</b>		
	<input type="checkbox"/> In-Person	<input type="checkbox"/> Over Telephone	<input type="checkbox"/> Via Telemedicine <input type="checkbox"/> Previously*
	Member's Initials: _____	BHMP/ or other Prescribing Clinician's Initials: _____	
	Date: _____	Date: _____	
	Health Care Decision Maker's Initials** _____	Date: _____	
<b>TARGET SYMPTOMS TO BE ADDRESSED***</b>			
<b>MEDICATION</b>	<b>HOW WAS MEDICATION INFORMATION DISCUSSED?</b>		
	<input type="checkbox"/> In-Person	<input type="checkbox"/> Over Telephone	<input type="checkbox"/> Via Telemedicine <input type="checkbox"/> Previously*
	Member's Initials: _____	BHMP/ or other Prescribing Clinician's Initials: _____	
	Date: _____	Date: _____	
	Health Care Decision Maker's Initials** _____	Date: _____	
<b>TARGET SYMPTOMS TO BE ADDRESSED***</b>			
_____ <i>Member's Printed Name</i>	_____ <i>Member's Signature</i>	_____ <i>Member's Initials</i>	
_____ <i>Health Care Decision Maker's Printed Name</i>	_____ <i>Health Care Decision Maker's Signature</i>	_____ <i>Health Care Decision Maker's Initials</i>	
_____ <i>BHMP or other Prescribing Clinician's Printed Name</i>	_____ <i>BHMP or other Prescribing Clinician's Signature</i>	_____ <i>BHMP or other Prescribing Clinician's Initials</i>	

\* "Previously Discussed" indicates the medication has been discussed in a previous setting (Hospital, another clinic, etc.) or by another Behavioral health medical practitioner and you are verifying that the person continues to consent to treatment with this medication.

- \*\* Ensure the informed consent form with original patient's signature is located in patient's file. If consent obtained by telephone or through tele-medicine, individual may initial and date at the next face-to-face visit.
- \*\*\* Target Symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.