Consent for Treatment With

_____
(Name of Medication)

I, _____, am a patient of

Dr. Umoren. Dr. Umoren has informed me that he recommends that I

receive the medication _____ for the treatment of

my illness. He has informed me of the nature of the treatment and has explained

to me the risks of possible side effects, including

_____

[Insert when applicable: He/she specifically discussed the risk of tardive dyskenisia, which may cause involuntary tic-like movements in the face, tongue, neck, arms, and/or legs.]

I understand that although Dr. Umoren has explained the most common side

effects of this treatment to me, there may be other side effects, and that I should

promptly inform Dr. Umoren or another member of the staff if there are any

unexpected changes in my condition.

I understand that I may not be compelled to take this medication and that I may

decide to stop taking it at any time. I also understand that although Dr.

Dr. Umoren believes that this medication will help me, there is no guarantee as to the results that may be expected.

On this basis I authorize Dr. Umoren or anyone authorized by him to administer _____ at such intervals as he/she deems advisable.

Signed_____

Dated_____