BETHESDA PSYCHIATRY
Pavan Segal, M.D.

Child and Adolescent Medication Consent Form

Consent for Treatment with:

I, _____, consulted with Dr. Pavan Nath Segal, who has informed that he recommends that my child, _____, receive the above medication for the treatment of my child's illness. Dr. Segal has informed me of the nature of the treatment and has explained to me the risks of possible side effects. Dr. Segal has also informed me of the risks and benefits of alternatives to this treatment vs. no treatment.

The use of medications is intended to cause a favorable change in mind or body. Medications routinely cause, not only the intended, favorable effect, but also additional effects, which are called side effects. Although sometimes favorable, side effects are usually unfavorable. Most medication side effects are reversible (i.e., stopping the medication will stop the side effect) and cause no lasting damage. Some medication side effects are irreversible and do cause lasting damage. The use of any medication involves some risk.

I understand that although Dr. Segal has explained to me the most common side effects for this treatment there may be other possible side effects, and that I should promptly inform Dr. Segal if there are any unexpected changes in my child's condition.

I understand that I may not be compelled to have my child take this medication and that I may request, at any time, that the medication be discontinued. However, I understand and recognize that if I decide to discontinue the medication, my child may experience serious side effects, and agree to consult with Dr. Segal before making such a decision on how to safely discontinue this medication.

Dr. Segal will make treatment recommendations. It is my right and responsibility to accept, reject or request modification of his recommendations. I am free to ask her any questions about

the medications. I am free to get a second opinion at any time. I am free to call or write the manufacturer of the medication to get additional information.

I also understand that although Dr. Segal believes that this medication will help my child, there is no guarantee as to the results that may be expected. I also understand and consent that my child may need periodic diagnostic and/or laboratory testing to monitor the treatment.

I understand that Dr. Segal may need to see my child more frequently to start certain medication trials during the first month(s) of starting a medication in order to monitor medication responses and possible side effects discussed above. Once my child has stabilized on a medication, I understand that Dr. Segal needs to see my child regularly to monitor medication and responses and that if I do not bring my child for follow-up as recommended, Dr. Segal will not be able to continue to prescribe and monitor medication.

As a result of my understanding the benefits and risks of the proposed medication, I give my consent for my child to take the medication as recommended.

_____

Parent or legal guardian signature

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