Southern California Psychiatric Group, Inc
28125 Bradley Rd, Ste 220, Sun City, CA 92586

B Nallamothu, MD, Diplomate
The American Board of Psychiatry and Neurology
Sub-specialty in Child and Adolescent Psychiatry
CA License A 89852

Patient Name: _____ Date of Birth: _____

I am a patient of **Dr B Nallamothu, MD**

S/he has informed me that psychotropic medications have been recommended for treatment of my disorder. Although everyone's response to this medication is different, in many cases like mine, this medication has demonstrated that it is helpful in alleviating or reducing some of the signs and symptoms typical of my disorder. While there is no guarantee that this medication will be 100% effective, my provider's is of the opinion that there is no suitable alternative treatment for me, at this time, which is likely to be more effective.

I hereby acknowledge that my provider did discuss with me the various risks and benefits associated with taking the psychotropic medication, checked below.

- ❑ **Neuroleptic** **Name(s):**

  Dry mouth, constipation, blurred vision (close-up), and various rashes, blood pressure changes (drop in blood pressure with change of position), and muscle spasms. Tardive dyskinesia—a side effect that may or may not develop with taking neuroleptics, commonly after years of therapy, was discussed. Tardive dyskinesia is a condition that may occur while taking the medication or after the medication has been discontinued; and it consists of movement of certain muscles of the trunk (pelvis and hips).

- ❑ **Anti-Depressant (SSRI)** **Name(s):**

  Nausea, sleepiness, loss of strength, dizziness, insomnia, sweating, and ejaculatory delay.

- ❑ **Anti-Depressant (Tricyclic)** **Name(s):**

  Dry mouth, sedation, blurred vision, blood pressure changes, constipation, ECC changes, changes in heartbeat, urinary retention, allergic reaction.

- ❑ **Anti-Depressant (MAOI)** **Name(s):**

  Must adhere to a special diet and use special caution in taking other medication which can raise the blood pressure when combined with this medication for approximately two weeks after discontinuation, dry mouth, restlessness, allergic reaction.

- ❑ **Lithium Carbonate** **Name(s):**

  At therapeutic levels these side effects may be seen: tremors, nausea, vomiting, diarrhea, frequent urination, fatigue, thyroid changes, and allergic reactions. At higher levels these side effects may be seen: confusion, seizures, coma.

- ❑ **Mood Stabilizer** **Name(s):**

- ❑ **Anxiolytics and Sedatives** **Name(s):**

  Sedation, slowed reaction time, psychological and physical dependence, and allergic reaction.

- ❑ **Stimulant** **Name(s):**

  Nervousness, insomnia, decreased appetite and weight loss, rapid heartbeat, increased blood pressure, psychological and physical dependence.

- ❑ **Other** **Name(s):**

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Any of these medications may cause drowsiness and might increase the effects of alcohol or other sedatives (such as drowsiness or poor coordination). Caution in driving and operating machinery and other tasks requiring alertness and coordination should be exercised. This explanation of risks and benefits is not meant to be all-inclusive. There are other potential adverse reactions. I should promptly notify my provider and 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 understand that the symptoms of my disorder may return or worsen if I stop taking this medication.

I understand that taking psychotropic medication during pregnancy may cause increased risk to the fetus and that I take the responsibility of informing my provider of any possibility of my being pregnant.

After a period with a specific medication, my provider may determine that a different dosage of the same medication or a different type of medication may be necessary before the best medication is found.

I also understand that although my provider believes that this medication will help me, there is no guarantee as to the results that may be obtained. On this basis, I authorize my provider (or anyone authorized by him or her) to administer such doses of medication at such intervals as my provider believes is best. I also authorize my provider (or anyone authorized by him or her) to change the type of medication I am to receive or the doses of my medication to achieve the best results possible.

Signature of Patient	Printed Name
Signature of Legal Representative	Printed Name
Relationship of Legal Representative to Patient	Date

Provider Certification:
I the undersigned provider, hereby certify that I have discussed with the patient or the patient's legal representative the information described in this document. I further certify that the patient was encouraged to ask questions and that all questions were answered.

Provider Signature	Date

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CONTROLLED SUBSTANCE CONTRACT

Your physician is committed to treat your condition. Some medications are regulated with strict guidelines by State and Federal Agencies or by both. This agreement is a tool to establish a clear understanding of the situation for both your and the physician, within the law, for proper controlled substance use.

1. I understand that most controlled substances have a potential for dependency and abuse.
2. I understand that Narcotics are not psychiatric medications and SCPG doctor cannot prescribe them.
3. You must disclose all medication you receive (including all benzodiazepines or stimulants) from any external physician to your SCPG physician during every visit. You must not receive benzodiazepines or stimulants from any outside physician except when your SCPG doctor is out on vacation.
4. I understand that all my medication orders will be sent electronically and to only one pharmacy. Should there be need to change pharmacy, I will inform your office well in advance. Once the prescription is sent, I understand that my doctor's office can't resend the medication to different pharmacy.
5. The prescribing physician has your permission to discuss all diagnostic and treatment details with the dispensing pharmacists and/or other healthcare professionals who provide you care for the purpose of maintaining accountability.
6. I agree to keep all your medication safe, secure, and out of reach from children. If the medication is lost, stolen, gets wet, destroyed, left on airplane, etc., I understand that it will not be replaced until the next prescribing date or it may not be replaced at all.
7. I will not share, sell or otherwise permit others including spouse or family members to have access to these medications.
8. I agree to not consume excessive amount of alcohol in conjunction with prescribed controlled substances. I agree to not purchase, obtain, or use any illegal drugs. It is not recommended to mix benzodiazepines and opioid medication as it could lead to adverse outcomes.
9. During my treatment, I understand that unannounced urine drug screening could be requested and that I must comply with such requests. Any missed tests will be considered positive for drugs. Presence of unauthorized substances may result in termination of my treatment by my physician at SCPG.
10. I understand and consent that my Insurance, all my physician(s) and State and Federal authorities including my pharmacist(s) could review history of my controlled substance prescription records from time to time.
11. I understand that early refills or renewals will not be approved. I must remember to make and keep my appointments as recommended before I run out of my medication. No phone refills will be provided for any controlled substances.
12. I understand that failure to adhere the above requirements may result in cessation of my therapy with controlled substances prescribed by my doctor.

I affirm that I have read, understood, and accept all the above terms. I also affirm that I have full right and power to sign and bound by this agreement.

Signature of Patient	Printed Name
Signature of Legal Representative	Printed Name
Relationship of Legal Representative to Patient	Date