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INFORMED CONSENT TO TREAT WITH MEDICATION

I, _____, do hereby authorize my prescribing physician or nurse practitioner and any other providers working for (or prescribing for) Chris Pagnani MD PC / Rittenhouse Psychiatric Associates to prescribe the following medication(s):

I understand that the reason this/these medication(s) are being prescribed is to treat my illness. Furthermore, by signing this **Consent Form I am confirming that my provider has informed me of the nature of the treatment, the type of medication that I am taking and any subsequent risks or side effects associated with this/these medication (s). I also confirm that I understand the risks and side effects associated with this/these medication (s).**

Please check and initial one choice below:

_____ I am allergic to _____ _____
Initials

_____ I have no known allergies to medications _____
Initials

Female Patients:

_____ **Yes, I am pregnant.** My provider informed me of potential risks to me and my developing, new-born, or breastfed baby that may occur due to taking this/these medication(s) while pregnant/breastfeeding. My provider explained how taking this/these medication(s) while pregnant may benefit me. We agree together that the potential benefits outweigh the potential risks. _____
Initials

_____ **No, I am not currently pregnant.** I understand that taking this/these medication(s) may carry risk of harm to a developing, new-born, or breastfed baby. I agree to discuss any plans for pregnancy with my provider as soon as possible, if applicable. _____
Initials

I understand that I may not be compelled to take this/ these medication(s) and that I may discontinue this/these medication(s) at any time. However, I further understand that if I stop taking this/ these medication(s) I may experience serious side effects, and therefore, I should not discontinue taking the medication without the awareness and active participation of my physician or nurse practitioner.

OFF LABEL MEDICATION: Off- Label medication is defined as: The use of a drug to treat a condition or target symptom(s), even though the drug is not specifically approved to do so by the US Food and Drug Administration (FDA).

BLACK BOX WARNING: Black Box Warnings are defined as: The strictest warning put in the labelling of prescription drugs or drug products by the US Food and Drug Administration (FDA) when there is reasonable evidence of an association of a serious hazard with the drug.

My signature below indicates that:

1. I understand the contents of this release as well as my rights with respect to agreeing to or refusing any medication suggested to treat my illness.
2. This consent form was discussed with me in detail and that all of my questions were answered to my satisfaction.
3. The nature and rationale of treatment with this/these medication(s), explanation of possible side effects (including black box warnings) and whether this/these medication(s) is/are being prescribed for "OFF LABEL" use was also discussed and I have no further questions. Signing indicates that I believe the benefits of treatment outweigh the risks.

Patient Signature: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature

Prescriber/Witness Signature: _____ Date: _____
Typing Your Name Here Constitutes Legal Signature

Print this form

E-mail this form to: (Select person below)