_____ MD

Address:_____

_____

This form lets me instruct patients in writing on how to start taking a new medication when the dose must be increased gradually. At the same time I can give special instructions such as if the medication must be taken with food. I can advise about emergencies and remind about contacting the doctor. I can obtain written informed consent. Useful even for simple medication instructions for the cognitively impaired.

Protocol for Titrating One Medication

Patient _____ DOB _____ # _____ Date _____

Medicine Name _____ Dose Strength #1 _____

Dose Strength #2 _____

# of ☐ days OR ☐ weeks	Dose	☐ Special Instructions ☐ Take As Needed	Time of Day* →	8 AM	Noon	6 PM	Bedtime

* *See Page 2 for explanations* .Continued

* Time of Day: These are approximate. However, if you vary your medication schedule often or by many hours, or if you often skip doses, you can expect that your medication will not work very well, and you may have more noticeable side effects. A regular schedule is good for your mental health. Use this opportunity to organize your life.

☑ Please call me right away at ___-___-_____ if you have *any* concerns or adverse events that you think might be related to taking this medication. If it is after regular business hours or on a weekend, you may reach me on my cell phone, ___-___-_____. ***Stop taking the medication until we can talk.***

☑ People taking medications are still subject to unrelated medical events which may be severe or life-threatening. Therefore, if you have symptoms that would usually prompt you to call your primary care provider or go to an emergency room, go ahead and do that. ***Do not wait for me to return your call.***

☑ All people who take medications should carry with them an up-to-date card or sheet of paper listing all their medications, the doses, and the number of times each day you take them. I can give you a form that might make it easier for you to do this chore, and I would be happy to help you with it if you wish.

☐ If you decide to continue this medication, it is advisable for you to obtain and wear at all times a medical identifier stating this fact, so that, were you to suffer an accident or illness that made you unable to talk to caregivers, medical personnel would still find that out quickly.

Physician's Signature _____ **Date:** _____

Informed Consent: "Dr. _____ and I have discussed to my satisfaction the purposes of this medication, the scientific evidence for its effectiveness, possible risks and side effects, and possible alternatives to it. I understand that these alternatives include being in psychotherapy without medication, taking different medications, doing nothing different from what I am doing now, or doing nothing at all. I also understand that this medication may not work as I hope it will. I agree to take this medication as prescribed, hoping it will relieve my symptoms and improve my mental health."

Patient's Signature: _____ **Date:** _____