

# CHRISTOPHER BIR, M.D.

Child, Adolescent, and Adult Psychiatrist

McLean Professional Park  
1497 Chain Bridge Road, Suite 105  
McLean, VA 22101

Phone: 703-749-3003, Fax: 703-749-3004

## CONSENT FOR TREATMENT WITH MEDICATION

I, \_\_\_\_\_, born on \_\_\_\_\_, agree and consent for psychiatric treatment to include the use of medication.

I understand the potential risks and benefits of the medication as well as alternatives to medication. I also understand the risk and benefits of other treatment options including no treatment whatsoever. I understand that the risk of \_\_\_\_\_ includes possible side effects of (but not limited to) \_\_\_\_\_.

I understand that every person reacts differently to medications and that other side effects and reactions are possible.

The medication will attempt to improve the following issues or symptoms:

\_\_\_\_\_  
\_\_\_\_\_.

The initial dosage of \_\_\_\_\_ will be \_\_\_\_\_ and the expected dosage range will be \_\_\_\_\_.

Patient Question(s) and Physicians Response(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_.

I understand the information provided to me, and have been given the opportunity to discuss other treatments and to raise questions regarding the use of this medication. I will call or see my clinician promptly for any questions, problems, or concerns regarding treatment with this medication.

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE OF BIRTH

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
DATE