Name _____
DOB_____

MEDICATION for DEPRESSION or ANXIETY CONSENT FORM

☐ Selective Serotonin Reuptake Inhibitor (SSRI), specify:_____

☐ Selective Non-Epinephrine Reuptake Inhibitor (SNRI)

☐ Other, specify: _____

Dr._____ would like to begin/continue this medication to help you with the following problems:

☐ Persistent depressed or irritable mood
☐ Anxiety

All medications have side effects. These side effects vary from person to person.
Here are some of the side effects you may feel:

Common:

SSRI	**SNRI**
Nausea	Nausea
Nervousness	Dry mouth
Sleep disturbance	Constipation
Headache	Decreased appetite
Diarrhea	Fatigue
	Increased sweating

Rare:

SSRI	**SNRI**
Irritability	Mania
Mania	Urinary retention
Weight Gain	

Very rare, but potentially life-threatening:

Serotonin syndrome (high fevers, sweating and increased heart rate)
Thoughts or actions of harming themselves

IF YOU EXPERIENCE ANY OF THESE SIDE EFFECTS OR ANY OTHER UNUSUAL FEELINGS, PLEASE TELEPHONE THE OFFICE AT _____. IF THE CONCERN IS SEVERE ENOUGH, PLEASE PROCEED TO AN EMERGENCY ROOM.

We have reviewed the above medication and its possible side effects. We understand that we have the right to refuse medications, but agree to discuss this with our physician first. We also understand that if we have further questions regarding the above medication, we will discuss them with our physician.

_____
Parent/Legal Guardian Date

_____
Signature of Patient Date

_____
Prescribing Physician Date