Consent to use of Serotonin Reuptake Inhibitor Antidepressant Medication

The physician should initial numbers 1 thru 5 after discussing each with the detainee.

I, ___________________________, Alien#. ___________ hereby authorize
Dr. ___________ or his/her relief (designee), to prescribe fluoxetine (Prozac), paroxetine (Paxil), sertraline (Zoloft), or Citalopram Hydrobromide (Celexa) an antidepressant medication to me and to continue said medication as is recommended for my psychiatric treatment.

1.___This medication is useful because it has been found to be effective in treating depression and its associated symptoms including sadness, fatigue, hopelessness, sleeplessness, loss of appetite, loss of interests, loss of concentration, suicide, or self harm ideation. This medication may also be effective in treating other disorders, such as panic disorder, phobias, PTSD, and obsessive-compulsive disorders.

2.___This medication may improve your condition by relieving all or some of the symptoms mentioned above.

3.___Common side effects to this medication include, but are not limited to, diarrhea, tremor, drowsiness, dizziness, headache, tiredness, insomnia, nausea, and increased sweating. These effects are frequently temporary or can be controlled with a change in dosage. Less common complaints include skin rash, hives, chills, fever, swelling in feet or legs, fast heartbeat, excessive hunger, lack of energy, abnormal dreams, fast or irregular heartbeat, flushing, joint or muscle pain, seizures, and decreased sex drive. We have reviewed the fact that if you have conditions such as liver function impairment or kidney function impairment, it may be preferable to use other medication.

If any of the above symptoms occur, you should notify Medical Staff at sick call as soon as possible.

4___Not taking this medication as prescribed by the physician's instruction may lead to a worsening of symptoms. However, some symptoms of depression and related disorders may get better or even go away without taking medication. Also, the risk of suicide may be increased by not taking this medication.

5___Other treatment options include other medication with similar benefits. Other drugs may cause some of the same side effects you might experience with this medication. Other treatments may not include any medication, but may involve individual counseling by a psychologist or other medical professional.

Based upon interview, assessment, and medical record review, it is my opinion that this patient understands the proposed treatment, and **is competent** to give consent.
Physician Signature ___________________

Based upon interview, assessment, and medical record review, it is my opinion that this patient **is not competent** to give consent.
Physician Signature ________________

Other issues discussed:

The undersigned certifies that he/she has read the foregoing, or has had it explained in a language they understand, and hereby consents to treatment and has no additional questions.

____________________	_______________	___________
Detainee Signature	Alien Number	Date

____________________ ____________
Witness Signature Date

______________________________ ____________
Attending Psychiatrist or Physician Date

I understand that I may stop taking this medication at any time by contacting the physician. However, I understand that discontinuing the medication abruptly is generally not advisable.