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 buspirone (Buspar) an antianxiety 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 anxiety and its associated symptoms including constant worry, apprehension, restlessness, fatigue, difficulty in concentration, irritability, and sleep disorder. This medication may also be effective in treating other related disorders, such as panic disorder, phobias, and Post Traumatic Stress Disorder.

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

3.___Common side effects to this medication include, but are not limited to, drowsiness, dizziness or lightheadedness, headache, tiredness, or nervousness. These effects are frequently temporary or can be controlled with a change in dosage.

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 anxiety and related disorders may get better or even go away without taking 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. Alternative 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.