J&T Behavioral Health and
Counseling Services

700 Liberty Place
Sicklerville, NJ 08081
Tel: 856-776-7540
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Medication Information Acknowledgment and Consent

Patient Name: _____

I have been informed about my mental health condition(s) and the medications recommended for my treatment. I have received and reviewed the medication fact sheets, which explain the risks, benefits, possible side effects, adverse reactions, and special precautions.

I have also been given information about alternative treatment options and am satisfied with the explanation provided. I understand that I should share this information with my loved ones and any other healthcare providers involved in my care.

Medications discussed:

_____

_____

_____

I understand that:

- Some medications may be prescribed for “off-label” use, and I have been informed about this when applicable.
- I have the right to refuse medication. I also understand that my response to medication may be unpredictable, including anticipated benefits (such as symptom relief), possible side effects, and adverse reactions.
- I have been given the opportunity for my family to be involved in my care.

I agree to:

- Discuss any additional concerns with my prescriber at J&T Behavioral Health and Counseling Services.

- Inform my prescriber about any medications I am taking from other providers and any changes in my medical condition.
- Notify my prescribers outside J&T Behavioral Health and Counseling Services of any changes in my psychiatric medications.

I am aware that:

- I should not operate heavy machinery or drive until I understand how the medication affects me.
- I should not use alcohol or drugs while on these medications, as they may interfere with treatment.
- If I am pregnant or planning to become pregnant, I must discuss medication use with my prescriber due to possible risks to an unborn child.

I confirm that:

- I have been offered and/or given the Medication Information Fact Sheet(s) for my prescribed medication(s).
- I freely agree to take the prescribed medication(s).
- Between May 1 and September 30, I have received and reviewed the fact sheet on heat-related precautions.

☐ **Yes** ☐ **No** — Fact Sheet Provided for Prescribed Medications
☐ **Yes** ☐ **No** — Heat Precautions Fact Sheet Provided (May 1 – September 30)

Patient Signature: _____ Date: _____

Authorized Person (if not patient): _____
Relationship: _____ Date: _____

Prescriber Signature (MD/APN/PA): _____ Date: _____