

**CONSENT FOR USE OF PSYCHOTROPIC MEDICATIONS**

I, X \_\_\_\_\_ (parent/legal guardian of) \_\_\_\_\_

have been informed by Dr. Pueby about the nature and purpose of the treatment with LUVOX, its risks and benefits.

Additionally, I/we have been given more explanation by way of medication informational sheet/s describing possible risks or complications of the administration of the medication being recommended. Also, I/we have been informed that I/my child will be referred for any necessary medical work-up, whenever indicated.

I/We have sufficient opportunity to discuss my/my child's condition and my/his/her treatment with Dr. Pueby, and my questions have been answered to my satisfaction. I/We believe that I/we have adequate knowledge upon which to base an informed consent to the proposed treatment.

X  
\_\_\_\_\_  
Signature of Patient (Parent/Guardian)

\_\_\_\_\_  
Signature of Witness

X  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Date