

Informed Consent for Off-Label Medication Use

Patient Name: _____

Date of Birth: _____

Medication Name: _____

Proposed Use/Diagnosis: _____

I, _____, understand that the medication prescribed to me by my psychiatrist is being used "off-label."

Definition of Off-Label Use:

I understand that "off-label" means the U.S. Food and Drug Administration (FDA) has approved this medication for a specific condition or age group, but it has not been specifically approved for my current diagnosis. However, my doctor believes this medication is appropriate for my treatment based on professional judgment, clinical experience, or published medical research.

Acknowledgment of Risk and Benefits:

My doctor has explained the following to me:

- The reasons why this medication is being recommended for my condition.
- Potential benefits of the treatment.
- Common and serious side effects associated with this medication.
- Alternative treatments (FDA-approved and non-FDA-approved) available for my condition.

Consent:

I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand that I may stop this medication at any time after consulting with my doctor regarding a safe tapering schedule.

By signing below, I voluntarily consent to the off-label use of this medication as part of my psychiatric treatment plan.

Patient/Guardian Signature: _____

Date: _____

Physician Signature: _____

Date: _____