Salveo Integrative Health
311 Gwinnett Drive, Lawrenceville, GA 30046
770-910-9196, Fax: 770-910-9197

INFORMED CONSENT FOR MEDICATION

Name: _____ DOB_____

SHAHZAD M. HASHMI, MD OR _____ has explained that the best treatment for my problem would include the use of the following medications:

Medication:	Dosage Range
_____	_____
_____	_____
_____	_____
_____	_____

I have been given a copy of the:

( ) Patient Information Sheet ( ) Other written information

I have had the opportunity to discuss the risks, benefits, and potential side effect of the listed medications with my doctor, and have received a reasonable explanation.

I understand that medications of this type have been successful in treatment of similar symptoms in others. Further, I understand that there is no guarantee that these agents will be as effective with my particular symptoms. I agree to notify my physician in the even that I experience any side effects or problems with the above medications.

I have informed my doctor that: ( ) I am pregnant ( ) I am not pregnant ( ) N/A
( ) I have other known physical disorders:
_____

I voluntarily consent to take this medication. I also understand that I have the right to withdraw my consent and stop taking medication at any time. If I decide to discontinue the medication, I will tell my doctor immediately, he/she may explain how to safely stop my medication.

_____ _____
Patient/ Parent/ Guardian Signature Date

As a physician, I certify that these instructions have been disclosed to the patient (parent or guardian, if appropriate), and they fully understand and agree to take the medications.

_____ _____
Physician Signature Date