County of San Bernardino
Department of Behavioral Health

Verbal/Telephone Consent for Administration of Psychotropic Medication

Date

Client Name

Client Date of Birth

Verbal telephone consent was given by the following individual:

Parent, Legal Guardian, or Conservator Name

Relationship to Client

Medication(s)	Dosage range	Consented	
1.		☐ YES	☐ NO
2.		☐ YES	☐ NO
3.		☐ YES	☐ NO
4.		☐ YES	☐ NO
5.		☐ YES	☐ NO
6.		☐ YES	☐ NO

The medication(s) concern(s) and side effect(s) have been discussed with the consenting parent, legal guardian, or conservator.

This individual ☐ has/ ☐ has not agreed to come by the facility and sign the Consent for Medication form on/before _____.

By signing below, I certify that on the above stated date and time I contacted the individual listed and obtained an informed verbal consent for the medication(s) designated in this document.

Psychiatrist Name | Psychiatrist Signature | Date | Time

By signing below, I certify that I am authorized to witness and have witnessed the above transaction completely.

Witness Name | Witness Signature | Date | Time

Witness must be a medical professional