

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 12/17/2010

Completion of this form is voluntary. If not completed, the medication cannot be administered without a court order unless in an emergency.
 This consent is maintained in the client's record and is accessible to authorized users.

Name – Patient / Client (Last, First, MI)		ID Number	Living Unit	Birthdate
Name – Individual Preparing This Form		Name – Staff Contact		Name / Telephone Number – Institution

MEDICATION CATEGORY	MEDICATION	RECOMMENDED DAILY TOTAL DOSAGE RANGE	ANTICIPATED DOSAGE RANGE
Sedative, Hypnotic	Ambien; Ambien CR (zolpidem)	10mg (5mg in older adults)	

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.

Recommended daily total dosage range of manufacturer, as stated in Physician's Desk Reference (PDR) or another standard reference.

This medication will be administered Orally Injection Other – Specify:

1. Reason for Use of Psychotropic Medication and Benefits Expected (note if this is 'Off Label' Use)

Include DSM IV diagnosis or the diagnostic "working hypothesis."

2. Alternative mode(s) of treatment other than or in addition to medications include

Note: Some of these would be applicable only in an inpatient environment.

- Environment and / or staff changes
- Positive redirection and staff interaction
- Individual and / or group therapy
- Rehabilitation treatments / therapy (OT, PT, AT)
- Treatment programs and approaches (habilitation)
- Use of behavior intervention techniques

Other Alternatives:

3. Probable consequences of NOT receiving the proposed medication are

Impairment of -Work Activities -Family Relationships -Social Functioning

Possible increase in symptoms leading to potential

- Use of seclusion or restraints
- Limits on access to possessions
- Limits on personal freedoms
- Limit participation in treatment and activities
- Limits on recreation and leisure activities
- Intervention of law enforcement authorities
- Risk of harm to self or others

Other consequences

Note: These consequences may vary, depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

Medication : Ambien;
Ambien CR - (zolpidem)

4. Possible side effects, warnings and cautions associated with this medication are listed below. This is not an all inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text such as the PDR or the United States Pharmacopoeia Dispensing Information (USPDI). As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects, in order to enhance care and treatment.

Continued – Possible side effects, warnings and cautions associated with this medication.

Check with your doctor as soon as possible if any of the following less common side effects occur: clumsiness or unsteadiness; confusion—more common in older adults; mental depression.

Other less common side effects include: abdominal or stomach pain; abnormal or decreased touch sensation; abnormal sensation of movement; appetite disorder; balance disorder; binge eating; bladder pain; bloody or cloudy urine; burning, crawling, itching, numbness, prickling, "pins and needles," or tingling feelings; change in hearing; chest discomfort; chills; confusion about identity, place, and time; constipation; continuing ringing or buzzing or other unexplained noise in ears; daytime drowsiness; diarrhea; difficult, burning, or painful urination; difficulty in moving; difficulty swallowing; discouragement; double vision or other vision problems; drugged feelings; dryness of mouth; ear drainage; earache; eye redness; false or unusual sense of well-being; fear; feeling of unreality; feeling sad or empty; fever; flatulence; frequent bowel movements; frequent urge to urinate; general feeling of discomfort or illness; generalized slowing of mental and physical activity; headache; hearing loss; heartburn; hives or welts; itching ears; joint pain; lack of appetite; lack of feeling or emotion; lack or loss of self-control; lack or loss of strength; longer or heavier menstrual periods; loss of balance; loss of interest or pleasure; memory problems; mood swings; muscle aches, cramping, pain or stiffness; nausea; nervousness; nightmares or unusual dreams; pain in joints; redness of skin; redness or soreness of throat; sense of detachment from self or body; shortness of breath or troubled breathing; skin rash; skin wrinkling; sneezing; sore throat; stress symptoms; stuffy or runny nose; swollen joints; tiredness; trouble concentrating; trouble sleeping; vision blurred; visual depth perception altered; vomiting.

Check with your doctor as soon as possible if any of the following rare side effects occur: dizziness, lightheadedness, or fainting; falling—more common in older adults; fast heartbeat; hallucinations (seeing, hearing, or feeling things that are not there); skin rash; swelling of face; trouble in sleeping; unusual excitement, nervousness, or irritability; wheezing or difficulty in breathing.

Before having any kind of surgery, dental treatment, or emergency treatment, tell the medical doctor or dentist in charge that you are using this medicine.

WARNING

- Need to evaluate for co-morbid diagnoses: Reevaluate if insomnia persists after 7 to 10 days of use.
- Severe anaphylactic/anaphylactoid reactions: Angioedema and anaphylaxis have been reported. Do not rechallenge if such reactions occur.
- Abnormal thinking, behavioral changes, complex behaviors: May include "sleep-driving" and hallucinations. Immediately evaluate any new onset behavioral changes.
- Depression: Worsening of depression or, suicidal thinking may occur. Prescribe the least amount feasible to avoid intentional overdose.
- Withdrawal effects: Symptoms may occur with rapid dose reduction or discontinuation.
- CNS depressant effects: Use can impair alertness and motor coordination. If used in combination with other CNS depressants, dose reductions may be needed due to additive effects. Do not use with alcohol.
- Elderly/debilitated patients: Use lower dose due to impaired motor, cognitive performance and increased sensitivity.
- Patients with hepatic impairment, mild to moderate COPD, impaired drug metabolism or hemodynamic responses, mild to moderate sleep apnea: Use with caution and monitor closely.

See PDR, USPDI or US Hospital Formulary Service for all-inclusive list of side effects.

Client Initial _____ Date _____

Medication : Ambien;
Ambien CR - (zolpidem)

By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client's social worker, case manager or psychologist.
4. I have the right to request a review at any time of my record, pursuant to ss. 51.30(4)(d) or 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client's social worker, case manager or agency / facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the **anticipated dosage range** without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s) and the probable consequences, which may occur if the proposed medication is not given. I have been given adequate time to study the information and find the information to be specific, accurate and complete.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

SIGNATURES

DATE SIGNED

Client – If Presumed Competent to Consent/Parent of Minor/Guardian (POA-HC)	Relationship to Client <input type="checkbox"/> Self <input type="checkbox"/> Parent <input type="checkbox"/> Guardian (POA-HC)	
Staff Present at Oral Discussion	Title	

Client / Parent of Minor / Guardian (POA-HC) Comments

As parent/guardian (POA-HC) was not available for signature, he/she was verbally informed of the information in this consent.

Verbal Consent

Obtained by – PRINT – Staff Name	Date Obtained	Written Consent Received
Obtained from – PRINT – Parent / Guardian (POA-HC) Name	Date Expires	Date Received

Client Initial _____ Date _____