

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
Antidyskinetic	Artane (trihexyphenidyl)	1mg - 15mg	

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.

- | | |
|----------------------------------------------------------------------|----------------------------------------------------------------------------|
| <input type="checkbox"/> -Environment and / or staff changes | <input type="checkbox"/> -Rehabilitation treatments / therapy (OT, PT, AT) |
| <input type="checkbox"/> -Positive redirection and staff interaction | <input type="checkbox"/> -Treatment programs and approaches (habilitation) |
| <input type="checkbox"/> -Individual and / or group therapy | <input type="checkbox"/> -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

- | | |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------|
| <input type="checkbox"/> -Use of seclusion or restraints | <input type="checkbox"/> -Limits on recreation and leisure activities |
| <input type="checkbox"/> -Limits on access to possessions | <input type="checkbox"/> -Intervention of law enforcement authorities |
| <input type="checkbox"/> -Limits on personal freedoms | <input type="checkbox"/> -Risk of harm to self or others |
| <input type="checkbox"/> -Limit participation in treatment and activities | |

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.

See Page 2

Client Initial _____ Date _____

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.

More common side effects include blurred vision; constipation; decreased sweating; difficult or painful urination (especially in older men); drowsiness; dryness of mouth, nose, or throat; increased sensitivity of eyes to light; nausea or vomiting.

Less common side effects include dizziness or lightheadedness when getting up from a lying or sitting position; false sense of well-being (especially in the elderly or with high doses); headache; loss of memory (especially in the elderly); muscle cramps; nervousness; numbness or weakness in hands or feet; soreness of mouth and tongue; stomach upset or pain; unusual excitement (more common with large doses of trihexyphenidyl).

Check with your doctor as soon as possible if you experience confusion (more common in the elderly or with high doses); eye pain; skin rash.

Although trihexyphenidyl is not contraindicated for patients with cardiac, liver, or kidney disorders, or with hypertension, such patients should be maintained under close observation. Since the use of trihexyphenidyl may in some cases continue indefinitely and since it has atropine like properties, patients should be subjected to constant and careful long-term observation to avoid allergic and other untoward reactions. In as much as trihexyphenidyl possesses some parasympatholytic activity, it should be used with caution in patients with glaucoma, obstructive disease of the gastrointestinal or genitourinary tracts and in elderly males with possible prostatic hypertrophy. Geriatric patients, particularly over the age of 60, frequently develop increased sensitivity to the actions of drugs of this type, and hence, require strict dosage regulation.

Incipient glaucoma may be precipitated by parasympatholytic drugs such as trihexyphenidyl.

Tardive dyskinesia may appear in some patients on long-term therapy with antipsychotic drugs or may occur after therapy with these drugs have been discontinued. Antiparkinsonism agents do not alleviate the symptoms of tardive dyskinesia, and in some instances may aggravate them. However, parkinsonism and tardive dyskinesia often coexist in patients receiving chronic neuroleptic treatment, and anticholinergic therapy with trihexyphenidyl may relieve some of these parkinsonism symptoms.

WARNING: Patients to be treated with trihexyphenidyl should have a gonioscope evaluation and close monitoring of intraocular pressures at regular periodic intervals.

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

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.

Client Initial _____ Date _____

Medication : Artane - (trihexyphenidyl)

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 _____