

**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 |
|--------------------------|---|---|--------------------------|
| Mood – Stabilizing Agent | Eskalith; Eskalith-CR; Lithobid (Lithium) | 900mg - 1800mg<br>Children up to 12 years of age: Dose must be determined by the doctor |                          |

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.

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.

The most common side effects include increased frequency of urination or loss of bladder control—more common in women than in men, usually beginning 2 to 7 years after start of treatment; increased thirst; nausea (mild); trembling of hands (slight).

Check with your doctor as soon as possible if any of the following less common side effects occur: Confusion, poor memory or lack of awareness; fainting; fast or slow heartbeat; frequent urination; irregular pulse; increased thirst; stiffness of arms or legs; troubled breathing (especially during hard work or exercise); slurred speech; unusual tiredness or weakness; weight gain.

Other less common side effects may include: acne or skin rash; bloated feeling or pressure in the stomach; muscle twitching (slight).

Check with your doctor as soon as possible if any of the following rare side effects occur: Blue color and pain in fingers and toes; coldness of arms and legs; dizziness; eye pain; headache; noises in the ears; vision problems.

Check with your doctor immediately if any of the following occur:

Early symptoms of overdose or toxicity: Diarrhea; drowsiness; lack of coordination; loss of appetite; muscle weakness; nausea or vomiting ; slurred speech; trembling.

Late symptoms of overdose or toxicity: Blurred vision; clumsiness or unsteadiness; confusion; convulsions (seizures); dizziness; increase in amount of urine; ringing in the ears; trembling (severe).

Caution – Lithium levels will rise as individual becomes dehydrated; some side effects become accentuated.

Signs of low thyroid function: Dry, rough skin; hair loss; hoarseness; mental depression; sensitivity to cold; swelling of feet or lower legs; swelling of neck; unusual excitement

### BLACK BOX WARNING

Toxicity closely related to serum concentrations and may occur at doses close to therapeutic levels. Equipped facilities should be identified prior to initiation of therapy to provide prompt and accurate serum concentration data.

### MONITORING RECOMMENDATIONS RELATED TO BLACK BOX DATA

Dosage must be individualized according to serum levels and clinical response. Regular monitoring of the patient's clinical state and serum lithium levels is necessary.

—Acute Mania: Desirable serum lithium levels are 1 to 1.5 mEq/L. Determine serum levels twice per week during acute phase, and until the serum levels and clinical condition have stabilized.

—Long term control: Desirable serum lithium levels are 0.6 to 1.2 mEq/L. In uncomplicated cases receiving maintenance therapy, determine serum levels at least every two months.

—Blood samples for serum lithium determinations should be drawn immediately prior to the next dose when concentrations are relatively stable. Total reliance must not be based on serum levels alone. Patient evaluation is required.

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 : Eskalith; Eskalith-CR; Lithobid - (Lithium)

| <b>SIGNATURES</b>   |  | <b>DATE SIGNED</b> |
|---|--|--------------------|
| Client – If Presumed Competent to Consent/Parent of Minor/Guardian (POA-HC) | Relationship to Client <input type="checkbox"/> Self<br><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 \_\_\_\_\_