DEPARTMENT OF HEALTH SERVICES
Division of Mental Health and Substance Abuse Services
F-24277 (12/2010)

STATE OF WISCONSIN
42 CFR483.420(a)(2)
DHS 134.31(3)(o)
DHS 94.03 & 94.09
s.51.61(1)(g) & (h)

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
Antidepressant (SSRI)	Paxil; Paxil CR; Pexeva (paroxetine)	10mg – 60mg	

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.

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.

The most common side effects include: acid or sour stomach; belching; decreased appetite; decreased sexual ability or desire; excess air or gas in stomach or intestines; heartburn; nervousness; pain or tenderness around eyes and cheekbones; passing gas; problems in urinating; runny or stuffy nose; sexual problems, especially ejaculatory disturbances; sleepiness or unusual drowsiness; stomach discomfort, upset, or pain; sweating; trauma; trembling or shaking; trouble in sleeping.

Check with your doctor as soon as possible if any of the following side effects occur: agitation; chest congestion; chest pain; chills; cold sweats; confusion; difficulty breathing; dizziness, faintness, or lightheadedness when getting up from a lying or sitting position; fast, pounding, or irregular heartbeat or pulse; muscle pain or weakness; skin rash.

Other less common side effects may include: abnormal dreams; anxiety; bladder pain; body aches or pain; change in sense of taste; changes in vision; cloudy urine; confusion; congestion; difficulty in focusing eyes; difficulty in moving; discouragement, feeling sad or empty; drugged feeling; dryness of throat; excessive muscle tone; fainting or loss of consciousness; fast or irregular breathing; feeling of unreality; feeling of warmth or heat; flushing or redness of skin, especially on face and neck; frequent urge to urinate; headache, severe and throbbing; heavy bleeding; increase in body movements; increased appetite; irritability; itching, pain, redness, or swelling of eye or eyelid; itching of the vagina or genital area; lack of emotion; loss of interest or pleasure; loss of memory; lump in throat; menstrual changes; menstrual pain or cramps; muscle twitching or jerking; pain during sexual intercourse; problems with memory; problems with tooth; rhythmic movement of muscles; sense of detachment from self or body; severe sunburn; slow heartbeat; sneezing; thick, white vaginal discharge with no odor or with a mild odor; tightness in throat; tingling, burning, or prickling sensations; trouble concentrating; voice changes; watering of eyes; weight loss; yawn.

Although rare, contact your physician immediately if any of the following side effects occur: absence of or decrease in body movements; bigger, dilated, or enlarged pupils [black part of eye]; difficulty in speaking; inability to move eyes; incomplete, sudden, or unusual body or facial movements; increased sensitivity of eyes to light; low blood sodium (confusion, convulsions [seizures], drowsiness, dryness of mouth, increased thirst, lack of energy); red or purple patches on skin; serotonin syndrome (confusion, diarrhea, fever, poor coordination, restlessness, shivering, sweating, talking and acting with excitement you cannot control, trembling or shaking, twitching); talking, feeling, and acting with excitement and activity you cannot control.

Avoid drinking alcoholic beverages while you are taking paroxetine.

This medicine may cause some people to become drowsy, to have trouble thinking, or to have problems with movement. Make sure you know how you react to citalopram before you drive, use machines, or do anything else that could be dangerous if you are not alert or well-coordinated.

Symptoms of serotonin syndrome (usually three or more occur together): Agitation; confusion; diarrhea; fever; overactive reflexes; poor coordination; restlessness; trouble breathing; shivering; sweating; talking or acting with excitement you cannot control; trembling or shaking; twitching.

BLACK BOX WARNING

Antidepressants and Suicidality

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in short term studies in children, adolescents, and young adults with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of this drug or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. This drug is not approved for use in pediatric patients.

MONITORING RECOMMENDATIONS RELATED TO BLACK BOX DATA—Close observation for suicidal thinking or unusual changes in behavior.

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

Client Initial _____ Date _____

Medication : Paxil; Paxil CR; Pexeva - (paroxetine)

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 ☐ Self ☐ Parent ☐ 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 _____