

**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)	Prozac (fluoxetine)	10mg – 80mg	

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.

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 side effects occur: decreased sexual drive or ability; inability to sit still; restlessness; skin rash, hives, or itching.

Other common side effects may include: anxiety or nervousness; decreased appetite; diarrhea; drowsiness; headache; increased sweating; nausea; tiredness or weakness; trembling or shaking; trouble in sleeping.

Check with your doctor as soon as possible if any of the following side effects occur: chills or fever; joint or muscle pain.

Other less common side effects may include: abnormal dreams; change in sense of taste; changes in vision; chest pain; constipation; dizziness or light-headedness; dryness of mouth; feeling of warmth or heat; flushing or redness of skin, especially on face and neck; frequent urination; hair loss; increased appetite; increased sensitivity of skin to sunlight; menstrual pain; stomach cramps, gas, or pain; vomiting; weight loss; yawning.

Although rare, check with your doctor as soon as possible if any of the following side effects occur: Breast enlargement or pain; convulsions (seizures); fast or irregular heartbeat; purple or red spots on skin; symptoms of hypoglycemia (low blood sugar), including anxiety or nervousness, chills, cold sweats, confusion, cool pale skin, difficulty in concentration, drowsiness, excessive hunger, fast heartbeat, headache, shakiness or unsteady walk, or unusual tiredness or weakness; symptoms of hyponatremia (low blood sodium), including confusion, convulsions (seizures), drowsiness, dryness of mouth, increased thirst, lack of energy; symptoms of serotonin syndrome, including diarrhea, fever, increased sweating, mood or behavior changes, overactive reflexes, racing heartbeat, restlessness, shivering or shaking; talking, feeling, and acting with excitement and activity you cannot control; trouble in breathing; unusual or incomplete body or facial movements; unusual secretion of milk, in females.

Rare side effects include: breast enlargement or pain, hypoglycemia (low blood sugar), irregular or fast heartbeat, convulsions (seizures), hepatitis, increased bleeding time, gout eczema, cataracts, deafness, double vision, glaucoma and loss of taste.

Avoid drinking alcohol while you are taking fluoxetine.

If you develop a skin rash or hives, stop taking fluoxetine and check with your doctor as soon as possible.

For diabetic patients: This medicine may affect blood sugar levels. If you notice a change in the results of your blood or urine sugar tests or if you have any questions, check with your doctor.

This medicine may cause some people to become drowsy or less able to think clearly, or to have poor muscle control. Make sure you know how you react to fluoxetine before you drive, use machines, or do anything else that could be dangerous if you are not alert and well able to control your movements .

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.

#### **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 : Prozac - (fluoxetine)

**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 \_\_\_\_\_