

**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	Remeron; Remeron SolTab (mirtazapine)	15mg - 45mg	

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 : Remeron;  
Remeron SolTab - (mirtazapine)

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

The most common side effects include constipation; dizziness; drowsiness; dryness of mouth; increased appetite; weight gain.

Check with your doctor as soon as possible if any of the following side effects occur: decreased or increased movement; mood or mental changes, including abnormal thinking, agitation, anxiety, confusion, and feelings of not caring; shortness of breath; skin rash; swelling.

Other less common side effects include: abdominal pain; abnormal dreams; back pain; dizziness or fainting when getting up suddenly from a lying or sitting position; increased need to urinate; increased sensitivity to touch; increased thirst; low blood pressure; muscle pain; nausea; sense of constant movement of self or surroundings; trembling or shaking; vomiting; weakness.

Although rare, check with your physician immediately if you experience convulsions (seizures); mouth sores; sore throat, chills, or fever.

Also, check with your doctor as soon as possible if any of the following side effects occur: decreased sexual ability; menstrual pain; missing periods; mood or mental changes, including anger, feelings of being outside the body, hallucinations (seeing, hearing, or feeling things that are not there), mood swings, and unusual excitement.

Other rare side effects include anxiety; breast enlargement in both males and females; hair loss; inappropriate secretion of milk--in females; increased sensitivity to sunlight; irritability; muscle twitching; red or brownish spots on skin; ringing, buzzing, or other unexplained sounds in the ears; seizures (more common with clomipramine); skin rash and itching; sore throat and fever; swelling of face and tongue; swelling of testicles (more common with amoxapine); trouble with teeth or gums (more common with clomipramine); weakness; yellow eyes or skin.

This medicine may add to the effects of alcohol and other medicines that make you drowsy or less alert. Check with your doctor before taking any other medicine.

Check with your doctor immediately if you develop fever, chills, sore throat, or sores in the mouth. These may be signs of a very serious blood problem that has occurred rarely in patients taking mirtazapine.

Mirtazapine may cause drowsiness or trouble in thinking. Make sure you know how you react to this medicine before you drive, use machines, or do other jobs that require you to be alert and clearheaded.

Dizziness, light-headedness, or fainting may occur, especially when you get up from a lying or sitting position. Getting up slowly may help. If this problem continues or gets worse, check with your doctor.

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.

### **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.

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Client Initial \_\_\_\_\_ Date \_\_\_\_\_

Medication : Remeron; Remeron SolTab - (mirtazapine)

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