

**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)	Zoloft (sertraline )	25mg – 200mg	

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.

Check with your doctor as soon as possible if any of the following side effects occur: decreased sexual desire or ability; failure to discharge semen (in men).

Other common side effects include: acid or sour stomach; belching; decreased appetite or weight loss; diarrhea or loose stools; dizziness; drowsiness; dryness of mouth; headache; heartburn; increased sweating; nausea; sleepiness or unusual drowsiness; stomach or abdominal cramps, gas, or pain; trembling or shaking; trouble in sleeping.

Check with your doctor as soon as possible if any of the following less common side effects occur: aggressive reaction; breast tenderness or enlargement; fast, pounding, irregular, or slow heartbeat; fast talking and excited feelings or actions that are out of control; fever; inability to sit still; increase in body movements; loss of bladder control; low blood sodium (confusion, convulsions [seizures], drowsiness, dryness of mouth, increased thirst, lack of energy); muscle spasm or jerking of all extremities; nose bleeds; red or purple spots on skin; restlessness; serotonin syndrome (diarrhea, fever, increased sweating, mood or behavior changes, overactive reflexes, racing heartbeat, restlessness, shivering or shaking); skin rash, hives, or itching; sudden loss of consciousness; unusual or sudden body or facial movements or postures; unusual secretion of milk (in females).

Other less common side effects may include: agitation, anxiety, or nervousness; bladder pain; burning, crawling, itching, numbness, prickling, "pins and needles," or tingling feelings; changes in vision, including blurred vision; cloudy urine; constipation; difficult, burning, or painful urination; flushing or redness of skin, with feeling of warmth or heat; frequent urge to urinate; increased appetite; pain or tenderness around eyes and cheekbones; stuffy or runny nose; vomiting.

Although rare, contact your physician immediately if you experience symptoms of serotonin syndrome. These usually include three or more of the following 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.

Other rare side effects may include: flushed, dry skin; fruit-like breath odor; increased hunger; increased thirst; increased urination; redness or other discoloration of skin; severe sunburn; swelling of breasts (in women); unexplained weight loss; unusual secretion of milk (in women).

## WARNINGS

**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 : Zoloft - (sertraline )

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