

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 03/01/16

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	Date of Birth
Name – Individual Preparing This Form		Name – Staff Contact		Name / Telephone Number – Institution

MEDICATION CATEGORY	MEDICATION	RECOMMENDED DAILY TOTAL DOSAGE RANGE	ANTICIPATED DOSAGE RANGE
Antipsychotic	Rexulti brexpiprazole	0.5-4 mg/day	

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-5 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 restraint | <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. 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.

What is the most important information I should know about REXULTI?

REXULTI may cause serious side effects, including:

- **Increased risk of death in elderly people with dementia-related psychosis.** Medicines like REXULTI can raise the risk of death in elderly who have lost touch with reality (psychosis) due to confusion and memory loss (dementia). REXULTI is not approved for the treatment of patients with dementia-related psychosis.
- **Risk of suicidal thoughts or actions.** Antidepressant medicines, depression and other serious mental illnesses, may cause suicidal thoughts or actions. REXULTI is not approved for the treatment of people younger than 18 years of age.
 - **Antidepressant medicines may increase suicidal thoughts or actions in some children, teenagers, or young adults within the first few months of treatment.**
 - **Depression and other serious mental illnesses are the most important causes of suicidal thoughts or actions. Some people may have a particularly high risk of having suicidal thoughts or actions.** These include people who have (or have a family history of) bipolar illness (also called manic-depressive illness) or suicidal thoughts or actions.
 - **How can I watch for and try to prevent suicidal thoughts and actions in myself or a family member?**
 - Pay close attention to any changes, especially sudden changes, in mood, behaviors, thoughts, or feelings. This is very important when an antidepressant medicine is started or when the dose is changed.
 - Call the healthcare provider right away to report new or sudden changes in mood, behavior, thoughts, or feelings.....
 - Keep all follow-up visits with the healthcare provider as scheduled. Call the healthcare provider between visits as needed, especially if you have concerns about symptoms.

Call a healthcare provider right away if you or your family member has any of the following symptoms, especially if they are new, worse, or worry you:

thoughts about suicide or dying; new or worsening depression; feeling very agitated or restless; panic attacks; new or worsening irritability; an extreme increase in activity or talking (mania); attempts to commit suicide; new or worsening anxiety; acting on dangerous impulses; trouble sleeping (insomnia); acting aggressive, being angry, or violent; other unusual changes in behavior or mood

What else do I need to know about antidepressant medicines?

Never stop an antidepressant medicine without first talking to your healthcare provider. Stopping an antidepressant medicine suddenly can cause other symptoms. Stopping an antidepressant medicine suddenly can cause other symptoms.

REXULTI may cause serious side effects, including:

- Stroke in elderly people (cerebrovascular problems) that can lead to death.
- Neuroleptic Malignant Syndrome (NMS): Tell your healthcare provider right away if you have some or all of the following symptoms: high fever, stiff muscles, confusion, sweating, changes in pulse, heart rate, and blood pressure. These may be symptoms of a rare and serious condition that can lead to death. Call your healthcare provider right away if you have any of these symptoms.
- Uncontrolled body movements (tardive dyskinesia): REXULTI may cause movements that you cannot control in your face, tongue or other body parts. Tardive dyskinesia may not go away, even if you stop taking REXULTI. Tardive dyskinesia may also start after you stop taking REXULTI. Problems with your metabolism such as:
 - high blood sugar (hyperglycemia): Increases in blood sugar can happen in some people who take REXULTI. Extremely high blood sugar can lead to coma or death. If you have diabetes or risk factors for diabetes (such as being overweight or having a family history of diabetes), your healthcare provider should check your blood sugar before you start taking REXULTI and during your treatment. Call your healthcare provider if you have any of these symptoms of high blood sugar while taking REXULTI: feel very thirsty; feel very hungry; feel sick to your stomach; feel weak or tired; need to urinate more than usual; feel confused, or your breath smells fruity; increased fat levels (cholesterol and triglycerides) in your blood; weight gain. You and your healthcare provider should check your weight regularly.
 - Low white blood cell count
 - Decreased blood pressure (orthostatic hypotension). You may feel lightheaded or faint when you rise too quickly from a sitting or lying position.
 - Seizures (convulsions)
 - Problems controlling your body temperature so that you feel too warm.
 - Difficulty swallowing that can cause food or liquid to get into your lungs.

The most common side effects of REXULTI include weight gain and an inner sense of restlessness such as feeling like you need to move.

Medication : Rexulti, brexpiprazole

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 § 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 _____