

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 10/11/2021

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
Antianxiety Agent/Anticonvulsant (benzodiazepine)	Ativan (lorazepam)	Oral: 0.5 - 10mg per day usually in 2 to 3 divided doses.	

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.

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

Most Common Side Effects: dizziness; drowsiness; unsteadiness; headache; tiredness or weakness.

Less Common Side Effects: anxiety; confusion (may be more common in the elderly); fast, pounding, or irregular heartbeat; mental depression; abdominal or stomach cramps or pain; blurred vision or other changes in vision; changes in sexual desire or ability; constipation; diarrhea; dryness of mouth or increased thirst; false sense of well-being; headache; muscle spasm; nausea or vomiting; problems with urination; trembling or shaking; unusual tiredness or weakness.

Rare Side Effects: Check with your doctor immediately if any of the following side effect occur: abnormal thinking, including disorientation, delusions, or loss of sense of reality; agitation; behavior changes including aggressive behavior, bizarre behavior, decreased inhibition, or outbursts of anger; seizures; hallucinations (seeing, hearing, or feeling things that are not there); low blood pressure; muscle weakness; skin rash or itching; sore throat, fever, and chills; trouble in sleeping; uncontrolled movements of body including the eyes; unusual bleeding or bruising; unusual excitement, nervousness, or irritability; unusual tiredness or weakness (severe); yellow eyes or skin.

Caution

- **Withdrawal**

Abrupt termination of treatment may be accompanied by withdrawal symptoms such as headache, anxiety, tension, depression, insomnia, restlessness, confusion, irritability, seizures, and sweating. Seizures may be more common in patients with pre-existing seizure disorders or who are taking other drugs that lower the convulsive threshold such as antidepressants. Abrupt discontinuation of product should be avoided and a gradual dosage-tapering schedule followed after extended therapy.

- **Respiratory Depression**

Use of benzodiazepines, including lorazepam, both used alone and in combination with other CNS depressants, may lead to potentially fatal respiratory depression

- **Driving and Operating Heavy Machinery**

This medication may cause you to feel dizzy or drowsy. It is recommended to avoid driving, operating heavy machinery, or performing any other task that may be dangerous if not fully alert until you know how this medication affects you

- **Pre-Existing Depression**

Pre-existing depression may emerge or worsen during use of benzodiazepines including lorazepam. Lorazepam is not recommended for use in patients with a primary depressive disorder or psychosis

- **Physical and Psychological Dependence**

Use of benzodiazepines, including lorazepam, may lead to physical and psychological dependence.

Warning: [Black Box Warning]: Risk from concomitant use with opioids.

Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation.

Warning: [Black Box Warning]: Abuse, misuse, and addiction.

The use of benzodiazepines, including Ativan, exposes users to risks of abuse, misuse, and addiction, which can lead to overdose or death. Abuse and misuse of benzodiazepines commonly involve concomitant use of other medications, alcohol, and/or illicit substances, which is associated with an increased frequency of serious adverse outcomes. Before prescribing Ativan and throughout treatment, assess each patient's risk for abuse, misuse, and addiction.

Warning: [Black Box Warning]: Dependence and withdrawal reactions.

The continued use of benzodiazepines, including Ativan may lead to clinically significant physical dependence. The risks of dependence and withdrawal increase with longer treatment duration and higher daily dose. Abrupt discontinuation or rapid dosage reduction of Ativan after continued use may precipitate acute withdrawal reactions, which can be life-threatening. To reduce the risk of withdrawal reactions, use a gradual taper to discontinue Ativan or reduce the dosage.

Seek medical attention immediately if it is suspected that an overdose of medication has been taken.

See PDR for an all-inclusive list of side effects.

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 that 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 <input type="checkbox"/> Yes <input type="checkbox"/> No
Obtained from – PRINT – Parent / Guardian (POA-HC) Name	Date Expires	Date Received