INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 11/22/2016

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
Antihistamine (sedative, antianxiety)	Benadryl (diphenhydramine)	25mg – 300mg	

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.

☐ 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 restraint
☐ 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.

See Page 2

Client Initial _____ Date _____

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

The most common side effects include: dizziness, drowsiness, fatigue; dry mouth, nose, or throat; gastrointestinal upset, stomach pain, or nausea; headache; thickening of mucus.

Less Common Side Effects

Less common side effects include: blurred vision or any change in vision; body aches or pain; clumsiness or unsteadiness; congestion/nasal stuffiness; constipation; cough; difficult or painful urination/urinary retention; hoarseness; increased sweating; joint pain; muscle aching or cramping; muscle pains or stiffness/dystonia;skin tenderness/itching; nightmares; ringing or buzzing in ears; skin rash; swollen joints; indigestion, heartburn, stomach discomfort, upset or pain; tender swollen glands in neck; tremor; unusual excitement, nervousness, restlessness, insomnia, tremor. or irritability; nausea/vomiting.

Rare Side Effects

Check with your doctor immediately if any of the following rare side effects occur: abdominal or stomach pain; burning; chills; clay-colored stools or dark urine; cough; difficulty swallowing or breathing, shortness of breath; swelling; tightness in chest or wheezing; dizziness; fast or irregular heartbeat; fever; headache; hives/skin rash; itching; prickly sensations; puffiness or swelling of the eyelids or around the eyes, face, lips or tongue; redness of skin; seizures; tingling; unusual tiredness or weakness.

Check with your doctor as soon as possible if any of the following rare side effects occur: Sore throat; unusual bleeding or bruising; unusual tiredness or weakness.

Caution

Antihistamines will add to the effects of alcohol and other CNS depressants (medicines that slow down the nervous system, possibly causing drowsiness). Some examples of CNS depressants are sedatives, tranquilizers, or sleeping medicine; prescription pain medicine or narcotics; barbiturates; medicine for seizures; muscle relaxants; or anesthetics, including some dental anesthetics. Check with your doctor before taking any of the above while you are using this medicine.

This medicine may cause some people to become drowsy or less alert than they are normally. Even if taken at bedtime, it may cause some people to feel drowsy or less alert on arising. Some antihistamines are more likely to cause drowsiness than others. Make sure you know how you react to the antihistamine you are taking before you drive, use machines, or do anything else that could be dangerous if you are not alert.

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

Client Initial _____ Date _____

Medication : Benadryl - (diphenhydramine)

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 ☐ Self ☐ Parent ☐ 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 ☐ Yes ☐ No
Obtained from – PRINT – Parent / Guardian (POA-HC) Name	Date Expires	Date Received

Client Initial _____ Date _____