

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
Beta-Adrenergic Blocker	Corgard (nadolol)	40mg – 320mg	

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.

See Page 2

Client Initial _____ Date _____

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

Check with your doctor immediately if any of the following less common side effects occur: Blurred vision; chest pain or discomfort; confusion; dilated neck veins; dizziness, faintness, or lightheadedness when getting up from a lying or sitting position suddenly; extreme fatigue; irregular breathing; lightheadedness, dizziness, or fainting; paleness or cold feeling in fingertips and toes; shortness of breath; slow or irregular heartbeat; sweating; swelling of face, fingers, feet, or lower legs; tingling or pain in fingers or toes when exposed to cold; unusual tiredness or weakness; weight gain; wheezing.

Check with your doctor immediately if any of the following rare side effects occur: Burning, crawling, itching, numbness, prickling, "pins and needles," or tingling feelings; changes in behavior; cough; difficulty breathing; noisy breathing; slurred speech; tightness in chest.

Other rare side effects include: Bloating; continuing ringing or buzzing or other unexplained noise in ears; decreased interest in sexual intercourse; diarrhea; difficulty having a bowel movement (stool); drowsiness; dry mouth, eyes, or skin; excess air or gas in stomach or intestines; full feeling; gas in stomach; hair loss, thinning of hair; headache; hearing loss; heartburn; inability to have or keep an erection; itching skin; loss in sexual ability, desire, drive, or performance; loss of appetite; nausea; passing gas; rash; relaxed and calm; sleepiness; stomach pain; stomach soreness or discomfort; stuffy nose; vomiting; weight loss.

CAUTION – These medications should be used cautiously with individuals who have diabetes, asthma, or narrow angle glaucoma.

BLACK BOX WARNING

Beta-Blockers: Abrupt withdrawal not advised in patients with angina pectoris, CAD or ischemic heart disease. Severe exacerbation of angina and the occurrence of MI and ventricular arrhythmias have been reported in angina patients following abrupt discontinuation. When discontinuation of these drugs is planned, patients should be carefully observed and advised to limit physical activity to a minimum. If the angina worsens or acute coronary insufficiency develops, it is recommended that nadolol be promptly reinstated, at least temporarily. Because CAD is common and unrecognized it may be prudent not to discontinue nadolol therapy abruptly in patients treated only for hypertension and in patients considered at risk of having occult atherosclerotic heart disease who are given nadolol for other reasons. Gradually reduce dosage over at least a few weeks (1 to 2 weeks). If angina markedly worsens or acute coronary insufficiency develops on drug withdrawal, reinstate therapy, at least temporarily. Advise patient against cessation or interruption of therapy without MD advice.

See PDR, USPDI or US Hospital Formulary Service for 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 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 _____