DEPARTMENT OF HEALTH SERVICES

Division of Care and Treatment Services F-24277 (05/2024)

STATE OF WISCONSIN 42 CFR483.420(a)(2) DHS 134.31(3)(o) DHS 94.03 & 94.09 §§ 51.61(1)(g) & (h)

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 04/05/2021

Completion of this form is voluntary. If an emergency. This consent is maintained in the clienters.		-			administered witho	ut a court c	order unless in	
This consent is maintained in the client's record and is accessible to at Name – Patient / Client (Last, First MI)			ID Num		Living Unit		Date of Birth	
Name – Individual Preparing This Form Name – Sta		Name – Staff Co	Contact		Name / Telephone Number – Institution		- Institution	
MEDICATION CATEGORY		MEDICATION DA			RECOMMENDED Y TOTAL DOSAGE RANGE		ANTICIPATE D DOSAGE RANGE	
Antidepressant	release); Ef	ffexor (venlafaxine immediate elease); Effexor XR (venlafaxine xtended release)		Immediate Release: 37.5 mg-375mg Extended Release: 37.5 mg-225 mg				
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 <i>Physician's Desk Reference</i> (PDR) or another standard reference. This medication will be administered Orally Injection Other – Specify:								
Reason for Use of Psychotropic Include DSM-5 diagnosis or the di				if this is 'Off	·Label' Use)			
2. Alternative mode(s) of treatmen Note: Some of these would be ap Environment and/or staff changes Positive redirection and staff intera Individual and/or group therapy Other Alternatives:	olicable only in a		nment. Rehal Treatr	oilitation treatm	nents/therapy (OT, and approaches (rvention techniques	habilitation)	
.3. Probable consequences of NOT	receiving the	proposed medica	tion are					
Impairment of Work Activities	☐ Fa	amily Relationships	8		☐ Social Function	ning		
Possible increase in symptoms lea Use of seclusion or restraint Limits on access to possessions Limits on personal freedoms Limit participation in treatment and Other Consequences:		ial	☐ Interv		and leisure activition nforcement authori or others			
Note: These consequences munusual situations, little or no a	nay vary depend adverse conseq	ling upon whether out	or not the if the med	individual is in lications are no	an inpatient settino ot administered.	g. It is also		
				Client	Initial	Date _	See Page 2	

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: excessive sweating; weight loss; anorexia; weight loss; nausea; dry mouth; dizziness; drowsiness; insomnia (difficulty falling asleep of staying asleep); abnormal muscle weakness or loss of muscle coordination; unusual tiredness; constipation; diarrhea; decreased ability to achieve orgasm in males.

Less Common Side Effects: dilation of blood vessels (may feel warm, or flushed); vomiting; tremor; decreased interest or desire in sexual activity; changes in the ability to achieve or maintain erection; changes in vision or blurred vision; increased cholesterol; abnormal dreams, yawning; nervousness; loss of feeling or tingling in the fingers, toes, or face.

Rare Side Effects: Although rare, talk to your physician if you experience any of the following: convulsions (seizures); itching or skin rash; lightheadedness or fainting, especially when getting up suddenly from a sitting or lying position; lockjaw or jaw stiffness; grinding of teeth or new tooth pain; chills; confusion; new or worsening depression or thoughts of suicide; hair loss; changes in menstrual period; problems in urinating or in holding urine; swelling or the face, tongue, or lips; acting with excitement and activity you cannot control; trouble breathing.

Caution:

Driving and operating heavy machinery

This medication, in some cases, may impair cognitive/motor performance, use caution operating machinery, driving, or anything else that could be dangerous if you are not alert and well able to control your movements.

- Bleed risk
 - Increased risk of bleeding if used with aspirin, NSAIDs (naproxen, ibuprofen), warfarin, or other anticoagulants.
- Psychosis/ Mania
 - May worsen psychosis in some patients or precipitate shift to mania or hypomania in patient with bipolar disorder.
- Weight loss
 - May cause anorexia and/or weight loss
- Withdrawa

Abrupt discontinuation or interruption may cause withdrawal symptoms. Please speak with your doctor before stopping this medication.

Serotonin syndrome

Serotonin syndrome (SS) is a potentially life-threatening syndrome that has occurred with serotonergic agents (eg, SSRIs, SNRIs), particularly when used in combination with other serotonergic agents (eg, triptans, TCAs, fentanyl, lithium, tramadol, buspirone, St John's wort, tryptophan) or agents that impair metabolism of serotonin (eg, MAO inhibitors intended to treat psychiatric disorders, other MAO inhibitors [ie, linezolid and intravenous methylene blue]). Monitor patients closely for signs of SS such as mental status changes (eg, agitation, hallucinations, delirium, coma); autonomic instability (eg, tachycardia, labile blood pressure, diaphoresis); neuromuscular changes (eg, tremor, rigidity, myoclonus); GI symptoms (eg, nausea, vomiting, diarrhea); and/or seizures. Discontinue treatment (and any concomitant serotonergic agent) immediately if signs/symptoms arise.

Decreased sexual function

This medication may cause or worsen sexual desire or function. If this becomes bothersome, please speak with your doctor about your concerns.

Warning: [Black Box Warning]: 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 ch	anges
in behavior.	-

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CICNIATURE

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					
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				

DATE CICNED