

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 05/27/2021

Completion of this form is voluntary. If informed consent is not given, 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
Alzheimer's treatment (does not cure or stop the disease but can improve thinking ability, treat the mild to moderate symptoms)	Exelon (rivastigmine)	Oral: 1.5 mg two times daily – 6 mg two times daily Transdermal (patch): 4.6mg—9.5mg daily	

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 impression ("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.

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: diarrhea; indigestion; loss of appetite; loss of strength; nausea and vomiting; weight loss; abdominal or stomach pain or cramping; skin swelling at the site of application (patch only); and tremor.

Less Common Side Effects: high blood pressure; fainting; general feeling of discomfort or illness; increased sweating; runny nose; bloated, full feeling; confusion; constipation; mental depression; dizziness; fatigue; headache; hallucinations; difficulty falling asleep or staying asleep; dehydration; increased abnormal, involuntary muscle movements; shuffling feet; difficulty walking; increased involuntary twitching.

Rare Side Effects: Check with your doctor as soon as possible if any of the following side effects occur: aggression; convulsions (seizures); severe trembling and shaking of hands and fingers; trouble urinating; swelling of the face, lips, or tongue; difficulty breathing; chest pain.

Symptoms of overdose: seizures; fast weak pulse; greatly increased sweating; greatly increased watering of mouth; irregular breathing; increasing muscle weakness; large pupils; low blood pressure; nausea; slow heartbeat; vomiting (severe).

Caution:

▪ **Gastrointestinal Adverse Reactions**

Rivastigmine use is associated with significant gastrointestinal adverse reactions, including nausea and vomiting, anorexia, and weight loss. This medication may increase the likelihood of experiencing nausea or vomiting. In the controlled clinical trials, 47% of the patients treated with a rivastigmine dose in the therapeutic range of 6-12mg/day (n=1189) developed nausea (compared with 12% in placebo). If this is severe, please call your doctor.

▪ **Weight Loss and Anorexia**

This drug is associated with potential undesirable weight loss, more common among women. It is not clear how much of the weight loss was associated with anorexia, nausea, vomiting, and the diarrhea associated with the drug. In clinical trials, of the patients treated with a rivastigmine dose of 6-12mg/day, 17% developed anorexia compared to 3% of the placebo patients. If you do experience weight loss, and this becomes severe or bothersome, please call your doctor promptly.

- **Peptic Ulcers/Gastrointestinal Bleeding:** This medication may be expected to increase gastric acid secretion. Therefore, patients should be monitored closely for symptoms of gastrointestinal or stomach bleeding, especially those at increased risk for developing ulcers, e.g., those with a history of ulcer disease or those receiving concurrent nonsteroidal antiinflammatory drugs (NSAIDs). Clinical studies of rivastigmine have shown no significant increase, relative to placebo, in the incidence of either peptic ulcer disease or gastrointestinal bleeding.

▪ **Driving and Operating Heavy Machinery**

This medication is associated with increased drowsiness or dizziness. 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 may affect you.

▪ **Skin Reactions**

This medication may, in rare instance, cause a skin reaction that involves the development of a rash and skin breakdown. If you do notice the development of a rash, or any other abnormal skin changes, please call your doctor.

▪ **Extrapyramidal Side Effects (EPS)**

This medication may cause, or worsen, extrapyramidal side effects. These side effects include tremor, increased clumsiness, shaking of the hands and fingers, uncontrollable movements, difficulty walking, and involuntary motions or twitches. If you do experience any of these symptoms, please call your doctor.

See standard reference text 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