

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
Beta-Adrenergic Blocker	Inderal, Hemangeol (propranolol) Inderal XL, InnoPran XL (propranolol extended release)	Immediate and extended release: 20 mg –320 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 *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.

- ☐ Environment and/or staff changes
- ☐ Rehabilitation treatments/therapy (OT, PT, AT)
- ☐ Positive redirection and staff interaction
- ☐ Treatment programs and approaches (habilitation)
- ☐ Individual and/or group therapy
- ☐ 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 recreation and leisure activities
- ☐ Limits on access to possessions
- ☐ Intervention of law enforcement authorities
- ☐ Limits on personal freedoms
- ☐ Risk of harm to self or others
- ☐ 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 or lightheadedness; unusually slow pulse; drowsiness; nausea; unusual tiredness or weakness and numbness or tingling of the fingers and / or toes; nightmares; diarrhea; altered sleep in infants; cold hands or feet.

**Less Common Side Effects:** difficulty breathing or wheezing; decreased appetite; mental confusion, swelling of ankles, feet and lower legs; anxiety and / or nervousness; constipation; headache; trouble sleeping; hallucinations; feeling of sadness and other symptoms of depression.

**Rare Side Effects:** Check with your doctor right away if you have any of the following symptoms while taking this medicine: blistering, peeling, or loosening of the skin; chills; severe cough; severe diarrhea; fever; itching and hives or rash; severe joint or muscle pain; red skin sores; sore throat; chest pain; signs of an allergic reaction (swelling of the lips, tongue, or throat; difficulty breathing; new onset rash or hives).

### Caution

- **Diabetes, Asthma, and Narrow-Angle Glaucoma**

This medication should be used cautiously with individuals who have diabetes, asthma, or narrow angle glaucoma.

- **Chest Pain**

There have been reports of a worsening of angina (chest pain) and, in some cases, heart attack, following abrupt stoppage of propranolol therapy. Therefore, when discontinuance of propranolol is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to restart propranolol therapy and take other measures appropriate as directed by your doctor. If you do experience severe or unusual chest pain, please call your doctor immediately.

- **Hypersensitivity and Skin Reactions**

Allergic reactions (swelling of the lips, tongue, or throat; difficulty breathing; new onset rash or hives) have been reported with this medication. If you do experience an allergic reaction after taking this medication, please call your doctor immediately. This medication may also cause a rare, yet severe skin rash. If you do notice an unusual rash, or other abnormal skin changes, please call your doctor promptly.

- **Cardiac Failure**

This medication can result in a slow heartbeat and dizziness. This medication may also worsen functional status in those diagnosed with heart failure. If you do notice side effects such as severe dizziness or unusually slow heartbeat, please talk to your doctor promptly. Additionally, if you are diagnosed with heart failure, please speak with your doctor before starting this medication.

- **Propranolol and Lung Disease**

In general, patients with bronchospastic lung disease (asthma, COPD, emphysema) should not receive beta-blockers. Propranolol should be administered with caution in this setting since it may provoke an asthma attack. If you have been diagnosed with lung disease, such as asthma, COPD, or emphysema, please speak with your doctor before starting this medication.

- **Diabetes and Hypoglycemia**

Beta-blockers, such as propranolol, may prevent the symptomatic detection of acute hypoglycemia (low blood sugar), especially in insulin-dependent patients. Please tell your doctor if you have been diagnosed with diabetes before starting this medication, and how you can better monitor for hypoglycemia.

- **Thyroid Disease**

Beta-blockers, such as propranolol, may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by a worsening of symptoms of hyperthyroidism. Therefore, please speak with your doctor before stopping this medication. Do not suddenly stop taking this medication.

### Warning: [Black Box Warning]: Abrupt Withdrawal

Beta-blocker therapy should not be abruptly stopped (particularly in patients with coronary artery disease), but gradually tapered to avoid acute rapid heart rate, severely elevated blood pressure, and/or ischemia (lack of oxygen delivery to the heart). Severe worsening of chest pain, ventricular arrhythmias, and heart attacks have been reported following abrupt withdrawal of beta-blocker therapy. Do not suddenly stop taking this medication. Rather, please speak with your doctor if desiring to stop this medication.

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