

## INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 06/17/2020

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
Hypnotic, Sedative	Lunesta (Eszopiclone)	1 mg to 3mg	

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:** headache; dizziness; drowsiness; altered sense of taste.

**Less Common Side Effects:** nervousness; depression; anxiety; confusion; migraine; nerve pain; abnormal dreams; hallucination; skin rash; itching; decreased sexual desire; swelling of male breast tissue; dry mouth; stomach pain; nausea; vomiting; diarrhea; increased incidence of urinary tract infections.

**Rare Side Effects:** Although rare, contact your physician as soon as possible if any of the following occur: chest pain; swelling in the lower legs; swelling of the face or tongue; abnormal thoughts or loss of memory; enlargement of breasts in males; agitation; increased appetite; skin photosensitivity; altered sense of smell; skin discoloration; loss of bladder control; vertigo; gastric ulcers; dry eye; hypertension (high blood pressure).

**Caution:**

- **Behavior Changes**  
Abnormal thinking/behavior changes including decreased inhibition, aggression, bizarre behavior, agitation, and hallucinations have been reported while using this medication.
- **Driving and Operating Heavy Machinery**  
Daytime function may be impaired at higher doses, take caution when performing tasks that require mental alertness such as operating machinery or driving after use. This is increased with less than a full night of sleep (7-8 hours).
- **Habit Forming**  
This medication may be habit-forming with prolonged use, do not use more than the prescribed dose.
- **Respiratory Conditions**  
Use with caution in patients with respiratory compromise, COPD, or sleep apnea.
- **Fall Risk**  
Avoid use in elderly, increased risk for delirium, dementia, cognitive impairments, or history of falls/ fractures.
- **Alcohol**  
Avoid use with alcohol, may result in additive central nervous system depressant effects.
- **Clinical Mental Depression**  
The use of this medication in patients with depression may result in worsening of depression and new or worsening suicidal thoughts. If you do experience worsening of depression, or new or worsening suicidal thoughts while taking this medication, please call your doctor right away.
- **Withdrawal**  
Do not abruptly stop taking this medication if you have been taking it for a prolonged period of time. Abrupt discontinuation can lead to withdrawal symptoms such as a rebound of insomnia. Please speak with your doctor before stopping this medication.
- **Fast onset**  
This medication has a fast onset. Be sure to administer only immediately before going to bed or once already in bed.

**Warning: [Black Box Warning] Complex sleep behaviors, including sleep-walking, sleep-driving, and engaging in other activities while not fully awake, may occur following the use of eszopiclone. Some of these events may result in serious injuries, including death.** Other complex sleep behaviors (eg, preparing and eating food, making phone calls, having sex) while asleep have also been reported. Patients usually do not remember these events. May occur with first use and at recommended dosages with or without the use of alcohol or other CNS depressants. **Discontinue immediately if a patient experiences a complex sleep behavior;** use is contraindicated in patients who have experienced these events.

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