|  |  |
| --- | --- |
| 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 MEDICATIONDosage and / or Side Effect information last revised on 06/08/2017 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 |
| MAO Inhibitor | Nardil  (phenelzine) | | | | | 15mg – 90mg | | |  |
| 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: | | | | | | | | | |
| 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. | | | | | | | | | |

See Page 2

| F-24277 | Medication: Nardil - (phenelzine) |
| --- | --- |
| 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 Check with your doctor as soon as possible if any of the following more common side effects occur: Dizziness or lightheadedness (severe), especially when getting up from a lying or sitting position.  Other more common side effects include: Blurred vision; decreased amount of urine; decreased sexual ability; dizziness or lightheadedness (mild), especially when getting up from a lying or sitting position; drowsiness; headache (mild); increased appetite (especially for sweets) or weight gain; increased sweating; muscle twitching during sleep; nausea; restlessness; shakiness or trembling; tiredness and weakness; trouble in sleeping. | |
| **Less Common Side Effects**  Check with your doctor as soon as possible if any of the following less common side effects occur: Diarrhea; fast or pounding heartbeat; swelling of feet or lower legs; unusual excitement or nervousness.  Other less common side effects include: Blurred vision; decreased amount of urine; decreased sexual ability; dizziness or lightheadedness (mild), especially when getting up from a lying or sitting position; drowsiness; headache (mild); increased appetite (especially for sweets) or weight gain; increased sweating; muscle twitching during sleep; nausea; restlessness; shakiness or trembling; tiredness and weakness; trouble in sleeping. | |
| **Rare Side Effects**  Check with your doctor as soon as possible if any of the following rare side effects occur: dark urine; fever; skin rash; slurred speech; sore throat; staggering walk; yellow eyes or skin.  Other rare side effects include: chills; constipation; decreased appetite; dryness of mouth. | |
| **Caution**  Stop taking this medicine and get emergency help immediately if any of the following effects occur:  Symptoms of unusually high blood pressure (hypertensive crisis); Chest pain (severe); enlarged pupils; fast or slow heartbeat; headache (severe); increased sensitivity of eyes to light; increased sweating (possibly with fever or cold, clammy skin); nausea and vomiting; stiff or sore neck. | |
| **Warning**  **Hypertensive Crisis**  The most important reaction associated with phenelzine is the occurrence of hypertensive crises which have sometimes been fatal.  These crises are characterized by some or all of the following symptoms: occipital headache which may radiate frontally, palpitation, neck stiffness or soreness, nausea or vomiting, sweating (sometimes with fever and sometimes with cold, clammy skin), and photophobia. Either tachycardia or bradycardia may be present, and associated constricting chest pain and dilated pupils may occur. Intracranial bleeding, sometimes fatal in outcome, has been reported in association with the paradoxical increase in blood pressure.    In all patients taking phenelzine, blood pressure should be followed closely to detect evidence of any pressor response. It is emphasized that full reliance should not be placed on blood pressure readings, but that the patient should also be observed frequently.  Therapy should be discontinued immediately upon the occurrence of palpitation or frequent headaches during therapy with phenelzine. These signs may be prodromal of a hypertensive crisis.  **Suicidality and Antidepressant Drugs**  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 care givers 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 changes in behavior. | |
| 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  Self  Parent  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 Yes  No | |
| Obtained from – PRINT – Parent / Guardian (POA-HC) Name | Date Expires | | Date Received | |