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| DEPARTMENT OF HEALTH SERVICES Division of Care and Treatment Services  F-24277 (09/2016) | STATE OF WISCONSIN 42 CFR483.420(a)(2)  DHS 134.31(3)(o)  DHS 94.03 & 94.09  §§ 51.61(1)(g) & (h) |

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| INFORMED CONSENT FOR MEDICATIONDosage and / or Side Effect information last revised on 06/17/2017 Completion of this form is voluntary. If not completed, 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 |
| Antipsychotic – First Generation (Typical); Phenothiazine Derivative | Prolixin  (Fluphenazine) | | | Oral: 2.5 mg to 40 mg per day  Short-acting Injection: 1.25 mg to 10mg per day  Decanoate Injection: 3.125 mg to 100 mg per every one to three weeks | | | | |  |
| 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 “working hypothesis.” | | | | | | | | | |
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| **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**: | | | | | | | | | |
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| 3. Probable consequences of NOT receiving the proposed medication are | | | | | | | | | |
| Impairment of  Work Activities | | Family Relationships | | | | | Social Functioning | | |
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| 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: Prolixin – (fluphenazine) |
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| 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; drowsiness; hypotension (low blood pressure); decreased sweating; dry mouth; nasal congestion. | |
| **Less Common Side Effects:** rough or “fuzzy” tongue; watering of the mouth; increased skin sensitivity to the sun; itching; weight gain; unusual secretion of milk in women; swelling of breast tissue; decreased interest in sexual activity/ability; constipation; difficulty in urinating; muscle spasm; tremor; change in color vision, or difficulty in seeing at night; fainting; loss of balance control; mask-like face; restlessness, or feeling the need to keep moving; shuffling walk; stiffness of arms or legs; trembling and shaking of hands and fingers; increased blinking or spasms of eyelid; lip smacking or puckering; muscle spasms of the face, neck, body, arms, or legs; puffing of the cheeks; rapid or worm-like movements of tongue; sticking out of tongue; tic-like or twitching movements; trouble breathing, speaking, or swallowing; uncontrollable chewing movements. | |
| **Rare Side Effects:** Although rare, contact you physician as soon as possible if the following occur: neuroleptic malignant syndrome (symtoms: severe confusion or coma; difficult or fast breathing; drooling; fast heartbeat; high/low irregular blood pressure; increased sweating; loss of bladder control; severe muscle stiffness; trembling or shaking; trouble with speaking or swallowing); irregular heart rate; recurrent fainting; inabitily to achieve ejaculation; glaucoma; seizure. | |
| **Caution**   * **Alcohol**   Avoid drinking alcohol while taking this medication.   * **Driving and Operating Heavy Machinery**   This medication 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 you movements   * **History of Cardiovascular Disease/ Seizures**   Use caution with severe cardiovascular disease, hepatic impairment, renal impairment, and with history of seizures.   * **Fall Risk**   This drug may increase risk of falls. Use caution in the elderly and those with a history of falls.   * **Orthostatic Hypotension**   This medication may cause dizziness upon standing. Please use caution by standing slowly from a seated or lying position.   * **Withdrawal**   Stopping this medication abruptly may cause physical withdrawal symptoms. Please speak with your doctor before stopping this medication.   * **Tardive Dyskinesia**   Abnormal movements that you cannot control in your face, tongue or other body parts. Tardive dyskinesia may not go away, even if you stop taking PROLIXIN. This may occur, with increased risk among elderly, especially elderly women, and patients treated with higher cumulative doses or longer treatment duration; discontinuation may be required.  **Warning:**  **[Black Box Warning]: Increased mortality in elderly patients with dementia-related psychosis:**  Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Analyses of 17 placebo-controlled trials (modal duration of 10 weeks), largely in patients taking atypical antipsychotic drugs, revealed a risk of death in drug-treated patients of between 1.6 to 1.7 times the risk of death in placebo-treated patients. Over the course of a typical 10-week controlled trial, the rate of death in drug-treated patients was about 4.5% compared with a rate of about 2.6% in the placebo group. Although the causes of death were varied, most of the deaths appeared to be either cardiovascular (eg, heart failure, sudden death) or infectious (eg, pneumonia) in nature. Observational studies suggest that, similar to atypical antipsychotic drugs, treatment with conventional antipsychotic drugs may increase mortality. The extent to which the findings of increased mortality in observational studies may be attributed to the antipsychotic drug as opposed to some characteristic(s) of the patients is not clear. Fluphenazine is not approved for the treatment of patients with dementia-related psychosis. | |
| See PDR 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. | |

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| **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 | |