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| DEPARTMENT OF HEALTH SERVICESDivision of Care and Treatment ServicesF-24277 (09/2016) | STATE OF WISCONSIN42 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 04/16/2021Completion 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 |
| Antidepressant | Pristiq(desvenlafaxine) | 25 mg-100 mg by mouth 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:       |
| 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.” |
|       |
| **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: Pristiq - (desvenlafaxine) |
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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; insomnia (difficulty falling asleep or staying asleep); excessive sweating; nausea; dry mouth. |
| **Less Common Side Effects:** orthostatic hypotension (dizziness when standing from a seated or lying position); fainting; fast heartbeat; high blood pressure; drowsiness; anxiety; fatigue; difficulty with ejaculation; abnormal dreams; unable to achieve orgasm; jitteriness; vertigo; depersonalization; uncontrollable contraction of muscles; seizures; altered attention; yawning; decreased sexual desire or function in males; hair loss; skin sensitivity to the sun; skin rash; weight gain; hot flashes; increased cholesterol; increased prolactin; constipation; decreased appetite; vomiting; grinding of teeth; tight, stiff jaw; increased protein in the urine; unable to obtain or maintain an erection; difficulty with urination; swelling of the face, lips, or tongue; tremor; weakness; blurred vision or other changes in vision; ringing of ears. |
| **Rare Side Effects:** Although rare, please contact your doctor as soon as possible if you experience any of the following side effects: difficulty breathing; swelling of the throat, tongue, or lips; chest pain; hives or severe rash; fever; upper abdominal pain that radiates to the back; abdominal pain that feels worse after eating. |
| **Caution:** * **Driving and operating heavy machinery**

This medication, in some cases, 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 your movements.* **Bleed risk**

Increased risk of bleeding if used with aspirin, NSAIDs (naproxen, ibuprofen), warfarin, or other anticoagulants.* **Psychosis/ Mania**

May worsen psychosis in some patients or precipitate shift to mania or hypomania in patient with bipolar disorder.* **Withdrawal**

Abrupt discontinuation or interruption may cause withdrawal symptoms. Please speak with your doctor before stopping this medication.* **Serotonin syndrome**

Serotonin syndrome (SS) is a potentially life-threatening syndrome that has occurred with serotonergic agents (eg, SSRIs, SNRIs), particularly when used in combination with other serotonergic agents (eg, triptans, TCAs, fentanyl, lithium, tramadol, buspirone, St John's wort, tryptophan) or agents that impair metabolism of serotonin (eg, MAO inhibitors intended to treat psychiatric disorders, other MAO inhibitors [ie, linezolid and intravenous methylene blue]). Monitor patients closely for signs of SS such as mental status changes (eg, agitation, hallucinations, delirium, coma); autonomic instability (eg, tachycardia, labile blood pressure, diaphoresis); neuromuscular changes (eg, tremor, rigidity, myoclonus); GI symptoms (eg, nausea, vomiting, diarrhea); and/or seizures. Discontinue treatment (and any concomitant serotonergic agent) immediately if signs/symptoms arise.* **Decreased sexual function**

This medication may cause or worsen sexual desire or function. If this becomes bothersome, please speak with your doctor about your concerns.* **Anxiety/ insomnia**

May cause increase in anxiety, nervousness, and insomnia. |
| **Warning: [Black Box Warning]: Antidepressants and Suicidality:** 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 caregivers 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 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 |