

**INFORMED CONSENT FOR MEDICATION**

**Dosage and / or Side Effect information last revised on 08/08/2016**

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 Agent (Phenothiazine) Antiemetic	(prochlorperazine)	5-10 mg orally 3-4 times a day Max of 150 mg for behaviors	

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 "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.

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

Constipation, drowsiness, dizziness, blurred vision, or dry mouth may occur. If any of these effects persist or worsen, notify your doctor or pharmacist promptly. To relieve dry mouth, suck on (sugarless) hard candy or ice chips, chew (sugarless) gum, drink water, or use a saliva substitute. Remember that your doctor has prescribed this medication because he or she has judged that the benefit to you is greater than the risk of side effects. Many people using this medication do not have serious side effects. Tell your doctor immediately if any of these unlikely but serious side effects occur: agitation/restlessness, face/muscle twitching, uncontrolled movements, drooling, trouble swallowing, difficulty talking, enlarged/tender breasts, unusual breast milk production, shaking (tremors), trouble urinating.

#### Rare Side Effects

Tell your doctor immediately if any of these rare but very serious side effects occur: dark urine, persistent nausea/vomiting, signs of infection (e.g., fever, persistent sore throat), severe abdominal pain, unusual bleeding/bruising, weakness, yellowing eyes/skin. This drug may infrequently cause a very serious (rarely fatal) nervous system disorder (neuroleptic malignant syndrome).

If you notice any of the following unlikely but very serious side effects, stop taking this medication and seek immediate medical attention: severe muscle stiffness, mental/mood changes (e.g., confusion, extreme drowsiness), very high fever, seizures, irregular/fast heartbeat, increased sweating.

In the unlikely event you have an allergic reaction to this drug, seek immediate medical attention. Symptoms of an allergic reaction include: rash, itching/swelling (especially of the face/tongue/throat), severe dizziness, trouble breathing. This is not a complete list of possible side effects.

#### Caution

**PRECAUTIONS:** Before taking prochlorperazine, tell your doctor or pharmacist if you are allergic to it; or to other phenothiazines (e.g., chlorpromazine); or if you have any other allergies. This product may contain inactive ingredients, which can cause allergic reactions or other problems. Talk to your pharmacist for more details.

This medication should not be used to treat patients who are unconscious or taking large amounts of any drug that causes drowsiness and slow/shallow breathing (e.g., alcohol, barbiturates, narcotics). Before using this medication, tell your doctor or pharmacist your medical history, especially of: blood disorders (e.g., bone marrow depression), ongoing breathing problems (e.g., asthma, emphysema), certain heart rhythm problems (e.g., prolonged QTc interval, irregular heartbeat), low blood pressure, glaucoma, liver problems (e.g., cirrhosis), Reye's syndrome, seizures, urination problems (e.g., trouble urinating due to enlarged prostate, urinary retention).

This drug may make you dizzy or drowsy or cause blurred vision. Do not drive, use machinery, or do any activity that requires alertness or clear vision until you are sure you can perform such activities safely. Limit alcoholic beverages. To minimize dizziness and light-headedness, get up slowly when rising from a sitting or lying position.

This medication may make you more sensitive to the sun. Avoid prolonged sun exposure, tanning booths, and sunlamps. Use a sunscreen and wear protective clothing when outdoors. This medication may decrease your body's ability to adjust to either very hot or very cold temperatures. Due to the risk of fainting, avoid being alone if exposed to temperature extremes (e.g., swimming in cold water). In hot weather, fever and heatstroke may occur due to decreased sweating. Avoid strenuous work/exercise, drink plenty of fluids, and dress lightly while in hot weather. The elderly may be more sensitive to the effects of this drug, especially low blood pressure, constipation, urinary problems, and nerve/muscle problems.

Children may be at greater risk for nerve/muscle side effects while using this drug. Therefore, this medication is not recommended for use in children who are in surgery or have a short-term illness (e.g., chickenpox, flu) or in children under 2 years old.

During pregnancy, this medication should be used only when clearly needed. Infants born to mothers who have used this medication during pregnancy may rarely have liver or nerve/muscle problems. Discuss the risks and benefits with your doctor. Based on information from related drugs, this medication may pass into breast milk. Therefore, breast-feeding while using this medication is not recommended. Consult your doctor before breast-feeding.

**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 seventeen 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 to 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 (e.g., heart failure, sudden death) or infectious (e.g., 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. Prochlorperazine maleate 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.

**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