

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 10/29/2018

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.

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|------------------------------------------|----------------------|---------------------------------------|---------------|
| 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 |
|---------------------|------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------|
| Anticonvulsant | Lyrica (pregabalin) | Adults: 150mg – 600mg per day Children over 4: Dose by body weight (If <30kg, not to exceed 14mg/kg/day. If 30kg or more, not to exceed 600mg/day) | |

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.

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|---------------------------------------------------------------------|---------------------------------------------------------------------------|
| <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 _____

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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.
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Continued – Possible side effects, warnings, and cautions associated with this medication.

Most Common Side Effects

Most common side effects include swelling of the extremities, dizziness, drowsiness, headache, fatigue, weight gain, dry mouth, incoordination, and double vision.

Less Common Side Effects

Less common side effects include increased appetite, changes in blood pressure, abnormal gait, euphoria, confusion, insomnia, disturbance of speech, decreased sex drive, constipation, muscle spasms, muscle aches or weakness, tremor, vertigo, infection, and increased creatinine kinase levels.

Rare Side Effects

Rare side effects include abnormal dreams, agitation, slow movements, changes in mood, cardiac failure, movement disorders, pancreatitis, blood disorders, and severe rash.

Caution

Cardiovascular: Use with caution in patients with severe cardiovascular disease, including heart failure. Weight gain and/or swelling of extremities may occur. In addition, the effect of weight gain/swelling may be additive with the thiazolidinedione class of antidiabetic agents. Close monitoring recommended.

Endocrine and Metabolic: Weight gain has been reported.

Hematologic: May decrease platelet count. Severe decreases in platelet count are extremely rare.

Immunologic: Angioedema, including life-threatening cases, has been reported, especially in patients with prior episode of angioedema or concurrently taking medications associated with angioedema (eg ACE inhibitors). Discontinue immediately if symptoms develop.

Immunologic: Hypersensitivity reactions, including skin redness, blisters, hives, rash, dyspnea, and wheezing have been reported. Discontinue immediately if symptoms develop.

Musculoskeletal: Creatinine kinase elevations have been reported. Discontinue if marked elevations occur, or if myopathy is suspected or diagnosed.

Neurologic: Significant dizziness and somnolence or sedation have been reported. Use caution when performing tasks which require mental alertness (such as operating machinery or driving).

Ophthalmic: Vision-related events, including reduced visual acuity, visual field changes, and blurred vision have been reported.

Psychiatric: Suicidal ideation and behavior, worsening of depression, and unusual changes in mood or behavior may occur as early as 1 week following initiation. Monitoring of mood recommended. If mood changes, report concerns immediately to healthcare provider.

Renal: Dosage adjustments recommended in kidney impairment. Use of extended-release tablet not recommended in patients with diminished kidney function or in patients undergoing hemodialysis.

Withdrawal: Withdrawal seizure or other adverse effects (such as insomnia, nausea, headache, anxiety, hyperhidrosis, and diarrhea) may be precipitated by abrupt discontinuation. Tapering over minimum of 1 week is recommended.

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 |