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| DEPARTMENT OF HEALTH SERVICESDivision of Care and Treatment ServicesF-24277 (05/2024) | 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 11/13/2017Completion 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 |
| Sedative, Hypnotic (benzodiazepine) | Restoril(temazepam) | Oral: 7.5mg - 30mg 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 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**:       |
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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. |

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| F-24277  | Medication: Restoril – (temazepam) |
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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 EffectsMost common side effects include a hangover effect (feeling groggy the day after you take temazepam); drowsiness, dizziness; nausea, vomiting. |
| **Less Common Side Effects**Less common side effects include loss of appetite; unsteadiness; tremor; increased dreaming; shortness of breath; irregular heartbeat; vomiting; backache; burning eyes; excessive sweating. |
| **Rare Side Effects**Rare side effects include amnesia; hallucinations; abnormal eye movement; paradoxical reactions including restlessness, overstimulation and agitationSeek medical attention immediately if it is suspected that an overdose of medication has been taken. |
| **BLACK BOX WARNING****Risks from concomitant use with opioids:**Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation.**WARNING**Because sleep disturbances may be the presenting manifestation of a physical and/or psychiatric disorder, symptomatic treatment of insomnia should be initiated only after a careful evaluation of the patient. The failure of insomnia to remit after 7 to 10 days of treatment may indicate the presence of a primary psychiatric and/or medical illness that should be evaluated. Worsening of insomnia or the emergence of new thinking or behavior abnormalities may be the consequence of an unrecognized psychiatric or physical disorder. Such findings have emerged during the course of treatment with sedative-hypnotic drugs. Because some of the important adverse effects of sedative-hypnotics appear to be dose related, it is important to use the smallest possible effective dose, especially in the elderly.Complex behavior such as “sleep-driving” (i.e., driving while not fully awake after ingestion of a sedative-hypnotic, with amnesia for the event) have been reported. These events can occur in sedative-hypnotic-naïve as well as in sedative-hypnotic-experienced persons. Although behaviors such as sleep-driving may occur with sedative-hypnotics alone at therapeutic doses, the use of alcohol and other CNS depressants with sedative hypnotics appears to increase the risk of such behaviors, as does the use of sedative-hypnotics at doses exceeding the maximum recommended dose. Due to the risk to the patients and the community, discontinuation of sedative-hypnotics should be strongly considered for patients who report a “sleep-driving” episode.Other complex behaviors (e.g., preparing and eating food, making phone calls, or having sex) have been reported in patients who are not fully awake after taking a sedative-hypnotic. As with sleep-driving, patients usually do not remember these events. Amnesia and other neuro-psychiatric symptoms may occur unpredictably. In primarily depressed patients, worsening of depression, including suicidal thinking has been reported in association with the use of sedative/hypnotics.**Abuse and Dependence** Withdrawal symptoms, similar in character to those noted with barbiturates and alcohol (convulsions, tremor, abdominal, and muscle cramps, vomiting, and sweating), have occurred following abrupt discontinuance of benzodiazepines. The more severe withdrawal symptoms have usually been limited to those patients who received excessive doses over an extended period of time. Generally milder withdrawal symptoms (e.g., dysphoria and insomnia) have been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Consequently, after extended therapy at doses higher than 15 mg, abrupt discontinuation should generally be avoided and a gradual dosage tapering schedule followed. As with any hypnotic, caution must be exercised in administering Restoril to individuals known to be addiction-prone or to those whose history suggests they may increase the dosage on their own initiative. It is desirable to limit repeated prescriptions without adequate medical supervision**Beers Criteria**Temazepam is identified in the Beers Criteria as a potentially inappropriate medication to be avoided in patients 65 years and older (independent of diagnosis or condition) due to increased risk of impaired cognition, delirium, falls, fractures, and motor vehicle accidents with benzodiazepine use. |
| 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.
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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 |