

INFORMED CONSENT FOR MEDICATION

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.

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
Central nervous system stimulant	Aptensio XR®; Concerta®; Cotempla XR-ODT®; Jornay PM®; Metadate CD®; Metadate ER®; Methylin®; QuilliChew ER®; Quillivant XR®; Relexxii®; Ritalin®; Ritalin LA®; (methylphenidate)	Immediate and extended release: 5 mg – 60 mg (72 mg for Concerta) 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:

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.

- ☐ 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:

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

- ☐ 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

Client Initial _____ Date _____

Medication: Aptensio XR®; Concerta®; Cotempla XR-ODT®; Daytrana®; Jornay PM®; Metadate ER®; Methylin®; QuilliChew ER®; Quillivant XR®; Relexxii®; Ritalin®; Ritalin LA® – (methylphenidate)

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

Most Common Side Effects weight decreased, decrease in appetite, nausea, vomiting, headache, insomnia, abdominal pain, dry mouth

Less Common Side Effects loss of appetite, labile affect, nasal congestion, nasopharyngitis, tic, palpitations, tachycardia, indigestion, oropharyngeal pain, vertigo, agitation, anxiety, lack of emotional response, restlessness, upper respiratory infection

Rare Side Effects

Caution

Precautions:

Heat: Avoid external heat source exposure with transdermal patch.

Cardiovascular: Sudden death and other serious cardiac diseases have been reported in patients with structural cardiac abnormalities treated with CNS stimulants. Avoid use in patients with known structural cardiac abnormalities, cardiomyopathy, serious cardiac arrhythmia, coronary artery disease, or other serious cardiac disease. Blood pressure and heart rate increases have been reported in patients taking CNS stimulants; monitoring recommended. Peripheral vasculopathy, including Raynaud phenomenon, has been reported; monitoring recommended.

Dermatologic: Contact sensitization may occur with transdermal patch; discontinuation and further diagnostics may be required. Permanent chemical leukoderma has been reported at sites distant from the patch application site, with a potential increased risk in patients with a personal or family history of vitiligo; monitoring recommended and discontinuation may be required.

Endocrine: Growth suppression has been reported in pediatric patients taking CNS stimulants; monitoring of height and weight is recommended and treatment interruption may be necessary.

Neurologic: CNS stimulants may lower the seizure threshold, especially in patients with a history of seizures, prior EEG abnormalities, and rarely in patients without a history; discontinue use if seizures are present. New onset or exacerbation of motor and verbal tics or Tourette's syndrome has been reported with CNS stimulants; assess family history prior to initiation. Monitoring recommended and discontinuation may be necessary.

Ophthalmic: Acute angle closure glaucoma has been reported; patients considered at risk (eg, patients with significant hyperopia) should be evaluated by an ophthalmologist. Elevation of intraocular pressure (IOP) and glaucoma have been reported; monitor patients with a history of abnormally increased IOP or open angle glaucoma.

Psychiatric: Induction of mixed or manic episodes may occur in patients with comorbid bipolar disorder; assess patients with comorbid depressive symptoms prior to initiation of treatment. Psychotic or manic symptoms (eg, hallucinations, delusional thinking, or mania) may occur in patients without prior history of psychotic illness or mania; discontinuation may be necessary. Exacerbation of behavior disturbance and thought disorder symptoms may occur in patients with pre-existing psychotic disorders with CNS stimulants.

Reproductive: Priapism, sometimes requiring surgical intervention, has been reported in both pediatric and adult patients.

Warning

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Syndrome Note

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