

INFORMED CONSENT FOR MEDICATION

Dosage and / or Side Effect information last revised on 09/07/2017

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
Antidepressant	Wellbutrin (multiple release forms); Zyban (bupropion)	150mg – 450mg	

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

Seizures: There is a chance of having a seizure (convulsion, fit) with WELLBUTRIN, especially in people: with certain medical problems or who take certain medicines. Do not take any other medicines while you are taking WELLBUTRIN unless your healthcare provider has said it is okay to take them. If you have a seizure while taking WELLBUTRIN, stop taking the tablets and call your healthcare provider right away. Do not take WELLBUTRIN again if you have a seizure.

High blood pressure (hypertension). Some people get high blood pressure that can be severe, while taking WELLBUTRIN. The chance of high blood pressure may be higher if you also use nicotine replacement therapy (such as a nicotine patch) to help you stop smoking.

Manic episodes. Some people may have periods of mania while taking WELLBUTRIN, including: Greatly increased energy, severe trouble sleeping, racing thoughts, reckless behavior, unusually grand ideas, excessive happiness or irritability, talking more or faster than usual. If you have any of the above symptoms of mania, call your healthcare provider.

Unusual thoughts or behaviors. Some patients have unusual thoughts or behaviors while taking WELLBUTRIN, including delusions (believe you are someone else), hallucinations (seeing or hearing things that are not there), paranoia (feeling that people are against you), or feeling confused. If this happens to you, call your healthcare provider.

Visual problems. Eye pain, changes in vision, swelling or redness in or around the eye. Only some people are at risk for these problems. You may want to undergo an eye examination to see if you are at risk and receive preventative treatment if you are.

Severe allergic reactions. Some people can have severe allergic reactions to WELLBUTRIN. Stop taking WELLBUTRIN and call your healthcare provider right away if you get a rash, itching, hives, fever, swollen lymph glands, painful sores in the mouth or around the eyes, swelling of the lips or tongue, chest pain, or have trouble breathing. These could be signs of a serious allergic reaction.

Less Common Side Effects

Other side effects include: Dry mouth; nervousness; confusion; dizziness; agitation; amblyopia “lazy eye”; blurred vision; constipation; headache; tremor; nausea; vomiting; insomnia; fast heartbeat; sweating.

Warning

BLACK BOX WARNING

WARNING: SUICIDAL THOUGHTS AND BEHAVIORS; AND NEUROPSYCHIATRIC REACTIONS SUICIDALITY AND ANTIDEPRESSANT DRUGS

Antidepressants increased the risk of suicidal thoughts and behavior in children, adolescents and young adults in short-term trials. These trials did not show an increase in the risk of suicidal thoughts and behavior with antidepressant use in subjects over age 24; there was a reduction in risk with antidepressant use in subjects aged 65 and older. In patients of all ages who are started on antidepressant therapy, monitor closely for worsening, and for emergence of suicidal thoughts and behaviors. Advise families and caregivers of the need for close observation and communication with the prescriber.

NEUROPSYCHIATRIC REACTIONS IN PATIENTS TAKING BUPROPION FOR SMOKING CESSATION

Serious neuropsychiatric reactions have occurred in patients taking bupropion for smoking cessation. The majority of these reactions occurred during bupropion treatment, but some occurred in the context of discontinuing treatment. In many cases, a causal relationship to bupropion treatment is not certain, because depressed mood may be a symptom of nicotine withdrawal. However, some of the cases occurred in patients taking bupropion who continued to smoke. Although WELLBUTRIN® is not approved for smoking cessation, observe all patients for neuropsychiatric reactions. Instruct the patient to contact a healthcare provider if such reactions occur.

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.

Medication : Wellbutrin (multiple release forms);
 Zyban - (bupropion)

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