

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
Antidepressant (SSRI)	Zoloft® (sertaline)	25 mg – 200 mg	

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

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.

Client Initial \_\_\_\_\_ Date \_\_\_\_\_

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** indigestion, loss of appetite, nausea, xerostomia, dizziness, sweating, diarrhea, headache, insomnia, somnolence, tremor, abnormal ejaculation, reduced libido, fatigue

**Less Common Side Effects** chest pain, palpitations, weight gain, weight loss, abdominal pain, constipation, increased appetite, purpuric disorder, myalgia, asthenia, hyperactive behavior, tinnitus, aggressive behavior, urinary incontinence, erectile dysfunction, rhinitis, sinusitis, yawning, fever

**Rare Side Effects** hemorrhage, increased liver enzymes, arthralgia, muscle weakness, seizures, hypomania, mania, priapism, bleeding from nose

### Caution

Precaution:

Cardiovascular: QTc prolongation and torsade de pointes have been reported, often in patients with other risk factors.

Endocrine and metabolic: Hyponatremia, usually the result of SIADH, has been reported; increased risk in patients with volume-depletion, elderly age, or concurrent diuretic therapy.

Gastrointestinal: Gastrointestinal hemorrhage has been reported; risk may be increased with concomitant use of aspirin, NSAIDs, warfarin, and other anticoagulants.

Hematologic: Bleeding events, including life-threatening hemorrhages, have been reported with SSRIs; risk may be increased with concomitant use of aspirin, NSAIDs, warfarin, and other anticoagulants.

Hepatic: Use not recommended in patients with moderate (Child-Pugh score 7 to 10) or severe hepatic impairment (Child-Pugh score 10 to 15).

Neurologic: Use caution in patients with a seizure disorder.

Ophthalmic: Angle closure attacks may occur in patients with anatomically narrow angles who do not have a patent iridectomy; avoid use in patients with untreated anatomically narrow angles.

Psychiatric: Mixed or manic episodes may occur in patients with bipolar disorder; screening prior to treatment recommended.

Reproductive: Increased risk of postpartum hemorrhage, especially when selective serotonin reuptake inhibitors (SSRIs) are used in the month prior to delivery. Symptoms of sexual dysfunction including ejaculatory delay or failure, decreased libido, and erectile dysfunction, have been reported in male patients; inquiry about sexual function prior to initiation and during therapy recommended. Symptoms of sexual dysfunction including decreased libido and delayed or absent orgasm, have been reported in female patients; inquiry about sexual function prior to initiation and during therapy recommended.

Special populations (Beers Criteria): Avoid use in elderly patients with a history of falls or fractures (unless safer alternatives are not available) as ataxia and impaired psychomotor performance may occur. Avoid concomitant use of 3 or more CNS-active agents in any combination due to increased risk of falls. Use with caution in elderly patients as this may cause or exacerbate SIADH or hyponatremia, and monitor sodium levels when starting or changing doses. Avoid using in combination with warfarin due to increased risk for bleeding, if use is required monitor INR.

Withdrawal: Serious discontinuation symptoms have been reported with serotonergic antidepressants upon abrupt withdrawal; gradual reduction recommended when possible.

### Warning

Black Box Warning: Oral (Solution; Tablet)

Suicidal Thoughts and Behaviors: Antidepressants increased the risk of suicidal thoughts and behavior in pediatric and young adult patients in short-term studies. Closely monitor all antidepressant-treated patients for clinical worsening, and for emergence of suicidal thoughts and behaviors.

**Syndrome Note**

Serotonin syndrome: Signs and symptoms include mental status changes (eg, agitation, hallucination, delirium, coma), autonomic instability (eg, tachycardia, labile blood pressure, dizziness, flushing, diaphoresis, hyperthermia), neuromuscular aberrations (eg, hyperreflexia, incoordination, tremor, rigidity, myoclonus), seizures, and gastrointestinal symptoms (eg, nausea, vomiting, diarrhea). Increased risk with concomitant use of other serotonergic drugs (including triptans, tricyclic antidepressants, fentanyl, meperidine, methadone, lithium, tramadol, tryptophan, buspirone, amphetamines, and St. John's Wort) and with drugs that impair metabolism (ie, MAOIs). This could be potentially life threatening.

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