

**INFORMED CONSENT FOR MEDICATION**

**Dosage and / or Side Effect information last revised on 07/10/2017**

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 (SSRI)	Zoloft (sertraline )	25mg – 200mg	

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

Common possible side effects in people who take ZOLOFT include: nausea, loss of appetite, diarrhea or indigestion, change in sleep habits including increased sleepiness or insomnia, increased sweating, sexual problems including decreased libido and ejaculation failure, tremor or shaking, feeling tired or fatigued, agitation.

### Caution

ZOLOFT and other antidepressant medicines may cause serious side effects, including:

1. Suicidal thoughts or actions: Zoloft and other antidepressants may increase suicidal thoughts or actions in some children, teenagers, or young adults within the first few months of treatment or when the dose is changed. Depression or other serious mental illnesses are the most important causes of suicidal thoughts or actions. Watch for these changes and call your healthcare provider right away if you notice: new or sudden changes in mood, behavior, actions, thoughts, or feelings, especially if severe. Pay particular attention to such changes when Zoloft is started or the dose is changed. Keep follow-up visits with your healthcare provider and call between visits if you are worried about symptoms.

Other side effects in children and adolescents include: abnormal increase in muscle movement or agitation, nosebleed, urinating more often, urinary incontinence, aggressive reaction, heavy menstrual periods, possible slowed growth rate and weight change. Your child's height and weight should be monitored during treatment with ZOLOFT.

**Zoloft may also be associated with these side effects and your healthcare provider should be contacted immediately:**

2. Feeling anxious or trouble sleeping.

3. Serotonin Syndrome: This condition can be life-threatening and may include:

agitation, hallucinations, coma or other changes in mental status, coordination problems or muscle twitching (overactive reflexes), racing heartbeat, high or low blood pressure, sweating or fever, nausea, vomiting, or diarrhea, muscle rigidity.

4. Severe allergic reactions: trouble breathing, swelling of the face, tongue, eyes or mouth, rash, itchy welts (hives) or blisters, alone or with fever or joint pain.

5. Abnormal bleeding: ZOLOFT and other antidepressant medicines may increase your risk of bleeding or bruising, especially if you take the blood thinner warfarin (Coumadin®, Jantoven®), a non-steroidal anti-inflammatory drug (NSAIDs, like ibuprofen or naproxen), or aspirin.

6. Seizures or convulsions.

7. Manic episodes, greatly increased energy, severe trouble sleeping, racing thoughts, reckless behavior, unusually grand ideas, excessive happiness or irritability, talking more or faster than usual.

8. Changes in appetite or weight. Children and adolescents should have height and weight monitored during treatment.

9. Low salt (sodium) levels in the blood. Elderly people may be at greater risk for this. Symptoms may include: headache, weakness or feeling unsteady, confusion, problems concentrating or thinking or memory problems.

Do not stop Zoloft without first talking to your healthcare provider. Stopping Zoloft too quickly may cause serious symptoms including: anxiety, irritability, high or low mood, feeling restless or changes in sleep habits; headache, sweating, nausea, dizziness; electric shock-like sensations, shaking, confusion.

### Warning

#### BLACK BOX WARNING

#### Suicidality and Antidepressant Drugs

Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of ZOLOFT or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. ZOLOFT is not approved for use in pediatric patients

Medication: - ( )

except for patients with obsessive-compulsive disorder (OCD).

**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.

**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