Name:       Case#:       Program:

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| CLIENT RIGHTSYou have the right to be informed about your care and to ask questions.You have the right to accept or reject any of your entire care plan.You have the right to end your consent verbally or in writing to any team member at any time.You have the right to language/interpreting services. *Services Requested?* YES NOYou have the right to a copy of this Consent: *Copy Requested?* YES NO **Emergency Treatment** *(An emergency is a temporary, sudden marked change requiring action to preserve life or prevent serious bodily harm to client or others)***:** In certain emergencies, medication may be given to you when it is not possible to get your consent. However, once the emergency has passed, your informed consent is required. | | | | | |
| **Medical staff will discuss with you the information below:** | | | | | |
| Your condition or diagnosis.Symptoms that the medication is expected to reduce, and how effective the medication is expected to be.Likelihood you will improve without medication.Whether or not other reasonable treatment are available.Medication type, dosage, frequency, route of administration, and expected duration of use.Common minor medication side effects as well as rare, but potentially more severe side effects, those that may take some time to develop, and risks specific to pregnant and breastfeeding women.If taking anti-psychotic medication*,* you will be given information about a possible side effect called tardive dyskinesia.It is characterized by involuntary movements of the face, mouth and/or hands and feet. These symptoms are potentially irreversible and may appear after medication has been discontinued.Above information explained to client? YES NO If no, document reason. | | | | | |
| **Medical staff is prescribing the following psychotropic medication(s) for you:** | | | | | |
| **Medication (name)** | **Dosage Range (how much)** | **Type**  **(class of meds)** | **Frequency (how often)** | **Duration (how long)** | **Oral (by mouth) or**  **Injection (by medical staff)** |
|  |  |  |  |  | OralInjection |
|  |  |  |  |  | OralInjection |
|  |  |  |  |  | OralInjection |
|  |  |  |  |  | OralInjection |
|  |  |  |  |  | OralInjection |
| The client has been offered medication information sheet for all medications. YES NO  **If no, document reason.** | | | | | |

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| **Client’s Consent**  **Based on the information I have read, discussed and/or reviewed with my medical staff:** (check one)  I understand and give consent/assent to take the psychotropic medication(s) on page one.  I give verbal consent but prefer not to sign form.  I prefer notto take the psychotropic medication(s) at this time. I understand that my treatment providers will continue to educate and offer me treatment.    Client/Legal Rep./Guardian Signature Date |
| Medical Staff Statement  I have reviewed, discussed and recommend the medication plan (page 1) for above client and:  Client gives consent to take these medications.  Client gives verbal consent, but prefers not (or is unable) to sign.  Client lacks capacity to provide informed consent. Legal representative gives consent/assent and/or Riese Authority has been obtained.  Client prefers not to take psychotropic medication at this time, but understands that treatment will continue to be offered.  Emergency. Client given medication without consent.  Other Comments:         Medical Staff Signature and License Date       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Medical Staff Printed Name and License         Witness Signature (if applicable): Date |