PSYCHOACTIVE MEDICATION THERAPY INFORMED CONSENT FORM

Use a separate form for each medication.

To protect our residents from harm to others and themselves, and to promote our residents for a higher level of independence, it is necessary to use psychoactive medical interventions under certain conditions. Medication interventions are NEVER used for disciplinary action or for the convenience of the facility to control behavior.

Psychoactive medication prescribed for resident_____

is _____ for the diagnosis of _____.

The specific condition(s) being treated include(s):

- ❑ Adjustment Disorder
- ❑ Agitation
- ❑ Anxiety
- ❑ Bipolar Disorder
- ❑ Catatonia
- ❑ Combative Behavior
- ❑ Dementia w/Psychotic Behavior
- ❑ Delusions
- ❑ Depression
- ❑ Irritability
- ❑ Obsessive Compulsive Behavior
- ❑ Panic
- ❑ Paranoia
- ❑ Schizophrenia
- ❑ Sexual Disorder
- ❑ Sleeping Disorder
- ❑ Socially Withdrawn
- ❑ Stress Disorder
- ❑ Other_____

The expected benefit(s) from the medical intervention include(s):

- ❑ Improved Functional Ability
- ❑ Reduced Adverse Behavior
- ❑ Other (please specify):_____

The clinically significant side effects possibly associated with this medical intervention include but are not limited to:

Antipsychotic	Anti-Anxiety	Hypnotic	Antidepressant	Anti-Manic	Psychomotor Stimulant
Blurred Vision	Appetite Changes	Anxiety	Appetite Changes	Bradycardia	Anorexia
Confusion	Blurred Vision	Confusion	Blurred Vision	Confusion	Dry Mouth
Constipation	Confusion	Dizziness	Constipation	Drowsiness	Impaired Taste
Drooling	Dizziness	Fatigue	Dry Mouth	Hypotension	Insomnia
Dry Mouth	Drowsiness	Hallucinations	Dyspepsia	Impaired Cognition	Nervousness
Involuntary Movements	Fatigue	Headache	Headache	Impaired Vision	
Muscle Rigidity	Hypotension	Lightheadedness	Hypotension	Nausea	
Restlessness	Nightmares	Mania	Insomnia	Nephritic Syndrome	
Sedation	Sedation	Nightmares	Weight Changes	Seizures	
Sleep Disturbances	Slurred Speech	Sedation	Urinary Retention	Tremors	
Stiffness of the Neck	Urinary Retention	Syncope			
	Dry Mouth				

The proposed course of therapy is approximately:

❑ 1 month ❑ 3 months ❑ 6 months ❑ 12 months ❑ Prolonged treatment / Unknown

❑ **I GIVE** my full consent for the use of the medication indicated above. I understand that once the targeted behavior is controlled, the usage of the medication should be gradually decreased to the lowest possible dosage and frequency.

❑ **I DO NOT GIVE** my consent for the use of the medication indicated above. I realize the dangers of not taking this medication may result in uncontrolled behaviors which may make it difficult for the nursing staff to appropriately provide care.

_____ _____
Signature of Resident Date

_____ _____
Signature of Representative Date

_____ _____
Signature of Person Obtaining Consent Date

_____ _____
Verbal Consent given by (full name and relation) Date

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed