CARE PLAN & INFORMED CONSENT FOR TAKING PSYCHOTROPIC MEDICATION

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.

- You have the right to be informed about your care and to ask questions.
- You have the right to accept or reject any of your 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 ☐ NO
- You have the right to a copy of this Care Plan & 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.

Prescriber will discuss with you the information below:

1. Nature and seriousness of your mental illness. **Diagnosis:**______________________________
2. Reason(s) for medication(s) including the likelihood of improving, or not improving with or without the medication(s), i.e. **Symptoms**______________________________
3. Reasonable alternative treatments and why doctor is recommending this particular treatment. Document alternative, if applicable: ______________________________
4. Medication type, dosage, frequency, duration, and method for taking medication(s): SEE BELOW
5. Commonly known probable side effects that you may experience: ______________________________
6. Possible additional side effects which may happen when taking medication(s) longer than three months:

   If taking a typical or atypical 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

Medical staff is prescribing the following psychotropic medication(s) for you:

Medication (name)	**Dosage Range (how much)**	**Frequency (how often)**	**Duration (how long)**	**Oral (by mouth) or Injection (by medical staff)**	
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection
				☐ Oral	☐ Injection

Client: ______________________________
Case#: ______________________________
Program: ______________________________

********Care Plan and Consent for Psychotropic Medications are required to be updated annually or when there is a change in psychotropic medications.***

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Client Statement

Based on the information I have read, discussed and/or reviewed with my medical staff: (check one)

☐ I understand and give consent to care plan and to take the psychotropic medication(s) on page one.

☐ I give verbal consent only; refuse to sign form.

☐ I **do not** consent to take the psychotropic medication(s) listed below.

Please list: ____

____

Client/Legal Rep./Guardian Signature Date

Prescriber Statement

I have reviewed, discussed and recommend the medication plan (page 1) for above client and:

☐ Client gives consent to care plan and to take these medications.

☐ Client gives verbal consent, but unwilling or unable to sign.

☐ Emergency. Client given medication without consent.

☐ Client unable to understand risks and benefits, and therefore cannot consent.

☐ Other Comments: ____

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Prescriber Signature and License Date

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Prescriber Printed Name and License

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Witness Signature (if applicable): Date

Client: ____

Case#: ____

Program: ____

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