INFORMED CONSENT for PSYCHOTHERAPEUTIC MEDICATION

TODAY'S DATE:

CONSENT EXPIRATION DATE:

The person providing this consent may withdraw consent orally or in writing before or during treatment, by notifying the prescribing practitioner or nurse on duty.

This consent is valid for a period not to exceed one year.
Psychotherapeutic medication therapy can not be initiated until consent or a court order is obtained.

N*	R*	Psychotherapeutic Medication	Dose Range	Route	Target Symptoms
Short-term objective/ goal of this medication:					
Short-term objective/ goal of this medication:					
Short-term objective/ goal of this medication:					
Short-term objective/ goal of this medication:					

Oral Consent: **(Note: For forensic clients committed under Chapter 916, F.S., consent must be in writing.)**

☐ YES ☐ NO (ETO initiated? ☐ Yes ☐ No)

☐ Telephone call: _____ (date/time)

☐ Meeting: _____ (date/time)

Person Providing Consent and relationship to resident

_____

Witness Signature / title / date if oral consent is obtained

_____

Prescribing Practitioner:

Print Name: _____

Facility Address: _____

_____

Facility Phone Number: _____

Tardive Dyskinesia (TD): Please check as appropriate.

Abnormal involuntary movements are:

☐ Present ☐ Not Present

☐ TD information sheet has been provided.

☐ TD is not applicable to the medication prescribed.

If TD is present or diagnosed – document plan:

Metabolic Syndrome:

☐ Metabolic Syndrome information sheet has been provided.

☐ Metabolic Syndrome not applicable to medication prescribed.

Neuroleptic Malignant Syndrome:

☐ Neuroleptic Malignant Syndrome information sheet has been provided.

☐ Neuroleptic Malignant Syndrome not applicable to medication prescribed.

Interpreter's Signature / title / date (if applicable):

1. DSM-5 Disagnosis: _____

2. Estimated length of time of treatment: _____

☐ **I have discussed possible other treatments with the person providing informed consent.**

☐ **I have discussed the attached information regarding the prescribed psychotherapeutic medication, the possible side affects, and potential medication interactions with the individual providing consent and it is my clinical opinion that the person understands the information provided.**

Medication information sheets: ☐ Given at meeting ☐ Sent with this form ☐ Not provided (documented reason in medical record)

☐ I have attempted to get in touch with the legal representative of this resident by phone at least three times but have been unable to make contact. By means of this document, the legal representative is hereby requested to sign and return this consent form. If further information is needed, please contact me to discuss this treatment plan at the above listed phone number.

_____

Signature/Title of Prescribing Practitioner **Date Signed**

Based on the information I have reviewed with the practitioner (check one of the following):

☐ I consent to the use of the psychotherapeutic medication(s) listed above.

☐ I do not consent to the psychotherapeutic medication(s) listed above.

☐ I consent to the use of the following medications (specify in comments):

Comments: _____

_____ _____

Signature of resident or person's legal representative **Date**

Relationship to resident if not signed by resident: _____

Addressograph

*N = New medication *R = Renewal of current medication

CF 1630, Jul 2014 [65E-20.003, F.A.C.] Distribution of Copies: Original – Medical record; Copy – Person providing consent