GARFIELD COUNTY HOSPITAL DISTRICT PSYCHOTROPIC MEDICATION INFORMED CONSENT

Patient/resident name:	Provider:	Medical Record #:

The following non-drug approaches have proven to be ineffective:

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Reason why medication was prescribed:

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Expected benefits to patient/resident:

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POTENTIAL SIDE EFFECTS: Refer to listing below for specific therapeutic class, medication & dosage

□ **Anti-depressant Medication:** Medication: ______________________
Dosage: ______________________

SIDE EFFECTS: Insomnia, fatigue, sexual dysfunction, nausea/vomiting, agitation, decreased appetite, sedation, skin rash
SPECIAL ATTENTION: If given with other sedatives, hypnotics and/or alcohol.

□ **Anti-Anxiety Medication:** Medication: ______________________
Dosage: ______________________

SIDE EFFECTS: Sedation, drowsiness, ataxia (drunk walk), dizziness, nausea, vomiting, confusion, headache, blurred vision, rash.
SPECIAL ATTENTION: If given with other sedatives, hypnotics and/or alcohol.

□ **Antipsychotic Medication**: Medication: ______________________
Dosage: ______________________

SIDE EFFECTS: Sedation, drowsiness, dry mouth, constipation, blurred vision
EXTRAPYRAMIDAL REACTION: Weight gain, edema, postural hypertension, sweating, loss of appetite, urinary retention
SPECIAL ATTENTION: Tardive dyskinesia, seizure disorder, chronic constipation, glaucoma, DM, skin pigmentation, jaundice

□ **Sedative/Tranquilizer Medication:** Medication: ______________________
Dosage: ______________________

SIDE EFFECTS: Sedation, drowsiness, morning hangover, ataxia (drunk walk)
SPECIAL ATTENTION: If given with other sedative, hypnotic and/or alcohol

The above information has been explained to me, I understand the Risk & Benefits of the medication. It is my desire to:
□ **Consent** to the use of this medication □ **Refuse** the use of this medication

Verbal consent given by (legal representative in behalf of patient/resident): ______________________________	**Date:**
Verbal consent requires two Facility Representative signatures:	**Date:**
Verbal consent requires two Facility Representative signatures:	**Date:**
Patient/Resident or Legal Representative signature:	**Date:**
Facility Representative signature:	**Date:**

THIS DOCUMENT WILL BE FILED IN THE PATIENT/RESIDENT MEDICAL RECORD AND WILL NOT BE THINNED AS LONG AS PATIENT/RESIDENT RECEIVES MEDICATION.

Date entered into service: 2-15-07 F-S-700-08