CONSENT FORM FOR PSYCHOTHERAPEUTIC DRUG USE

Resident's Name	Resident's Date of Birth

Facility Name	Facility Address	Facility Phone Number

Psychotherapeutic Drug

Drug Category	Drug Name	Dosage Range
Frequency	Duration	

Administration Method: ☐ Orally ☐ Injection ☐ Other – Specify:

Reason for Use of Psychotherapeutic Drug and Benefits Expected (i.e. off-label use, such as when a proposed drug is being prescribed for a purpose that has or has not been approved by the United States (US) Food and Drug Administration (FDA)):

Probable Side Effects and Significant Risks Associated With Use of the Psychotherapeutic Drug (i.e. current boxed warning labels, contraindications, warnings, precautions required by the US FDA, whether the drug has been approved by the US FDA, or possible interactions with other drugs the resident is receiving):

Reasonable Alternative Mode(s) of Treatment or Possible Nonpharmacological Approaches:

Resident's/Resident's Representative's Initials: _____

NOTE: Resident/Resident's Representative must initial at the bottom of each page where a psychotherapeutic drug is being prescribed. If page is left blank because it is not applicable (i.e. only one drug is prescribed), do not add initials.

Resident's Name: _____ Resident's Medical Record Number: _____

Psychotherapeutic Drug		
Drug Category	Drug Name	Dosage Range
Frequency	Duration	

Administration Method: ☐ Orally ☐ Injection ☐ Other – Specify:

Reason for Use of Psychotherapeutic Drug and Benefits Expected (i.e. off-label use, such as when a proposed drug is being prescribed for a purpose that has or has not been approved by the US FDA):

Probable Side Effects and Significant Risks Associated With Use of the Psychotherapeutic Drug (i.e. current boxed warning labels, contraindications, warnings, precautions required by the US FDA, whether the drug has been approved by the US FDA, or possible interactions with other drugs the resident is receiving):

Reasonable Alternative Mode(s) of Treatment or Possible Nonpharmacological Approaches:

Resident's/Resident's Representative's Initials: _____

NOTE: Resident/Resident's Representative must initial at the bottom of each page where a psychotherapeutic drug is being prescribed. If page is left blank because it is not applicable (i.e. only one drug is prescribed), do not add initials.

Resident's Name: _____ Resident's Medical Record Number: _____

Psychotherapeutic Drug		
Drug Category	Drug Name	Dosage Range
Frequency	Duration	

Administration Method: ☐ Orally ☐ Injection ☐ Other – Specify:

Reason for Use of Psychotherapeutic Drug and Benefits Expected (i.e. off-label use, such as when a proposed drug is being prescribed for a purpose that has or has not been approved by the US FDA):

Probable Side Effects and Significant Risks Associated With Use of the Psychotherapeutic Drug (i.e. current boxed warning labels, contraindications, warnings, precautions required by the US FDA, whether the drug has been approved by the US FDA,or possible interactions with other drugs the resident is receiving):

Reasonable Alternative Mode(s) of Treatment or Possible Nonpharmacological Approaches:

Resident's/Resident's Representative's Initials: _____

NOTE: Resident/Resident's Representative must initial at the bottom of each page where a psychotherapeutic drug is being prescribed. If page is left blank because it is not applicable (i.e. only one drug is prescribed), do not add initials.

Prescriber's Signature

By signing the below, I confirm that I have personally examined and provided and discussed with the resident and/or resident's representative the following material information:

- The reason for the treatment and the nature and seriousness of the patient's illness
- The nature of the procedures to be used in the proposed treatment including their probable frequency and duration
- The probable degree and duration (temporary or permanent) of improvement or remission, expected with or without such treatment
- The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions
- The reasonable alternative treatments and risks, and why the health professional is recommending this particular treatment
- That the patient has the right to accept or refuse the proposed treatment, and if he or she consents, has the right to revoke his or her consent for any reason at any time
- Possible nonpharmacologic approaches that could address the resident's needs
- Whether the drug(s) has a current boxed warning label along with a summary of, and information about how to find, the contraindications, warnings, and precautions required by the United States Food and Drug Administration
- Whether a proposed drug is being prescribed for a purpose that has or has not been approved by the United States Food and Drug Administration
- Possible interactions with other drugs the resident is receiving
- How the facility and prescriber will monitor and respond to any adverse side effects and inform the resident of side effects

My signature below also acknowledges that I will monitor and respond to any adverse side effects and inform the resident of side effects.

_____ _____

Prescriber's Name Prescriber's Signature

_____

Date

Resident's/Resident's Representative Signature

By signing the below, I give consent to treatment with the psychotherapeutic drug(s). I acknowledge and understand that I have the right to accept or refuse the proposed treatment, and if I consent, I have the right to revoke my consent for any reason at any time.

_____ _____

Resident's/Resident's Representative Name Resident's/Resident's Representative Signature

_____

Date

Emergency Treatment: In certain emergencies, medication may be given to you when it is not possible to get your consent. However, once the emergency has passed, it is still required to request your informed consent.

Licensed Nurse's Signature (if applicable)

If the signature of the resident or resident's representative cannot be obtained, a licensed nurse must sign the form and verify that they confirmed informed consent with the resident or resident's representative and state the name of the person with whom they verified informed consent and the date. The licensed nurse must verify the following and sign below:

The signature of the resident or resident's representative cannot be obtained despite diligent efforts. Confirmation of consent was obtained from:

_____ on _____
Resident's/Resident's Representative Name Date

_____ _____
Licensed Nurse's Name Licensed Nurse's Signature

_____
Date

Interpreter's Signature (if applicable)

If the resident or resident's representative cannot communicate with the licensed healthcare practitioner acting within the scope of his or her professional licensure because of language or communication barriers, the facility must arrange for an interpreter. When interpreters are used, documentation must be placed in the patient's health record indicating the name of the person who acted as the interpreter and his or her relationship to the patient and to the facility. The interpreter must sign the below:

_____ _____
Interpreter's Name Interpreter's Signature

_____ _____
Date Relationship to Resident and Facility