PATHWAY HEALTH
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Psychotropic Medication Informed Consent Form (Example)

Resident: _____ MR#: _____ Room#_____

Physician: _____

Type of medication ordered: (Use separate consent for each psychotropic medication ordered)
❑ Hypnotic/Sedative ❑ Antianxiety ❑ Antipsychotic ❑ Antidepressant ❑ Other: _____

Medication: _____ Dosage: _____ Frequency: _____

The following information has been explained about the psychotropic medication listed above:

The reason for use of this psychotropic medication: _____

The benefit (s) to be obtained in using this medication. _____
_____
_____

Alternative mode(s) of treatment other than OR in addition to medication include:

_____ _____ _____
_____ _____ _____

The potential side effects, black box warnings, etc., risks of medication (see reverse side).

Potential adverse consequences may include but are not limited to: Sedation, loss of functional decline, changes in mood or behavior, behavioral distress, agitation, decline in cognition, changes in appetite, potential changes in sleep patterns.

I can refuse consent or can withdraw my consent at any time. If I withdraw consent, I realize that some medication may require a gradual discontinuation.

Questions regarding this medication can be addressed with the interdisciplinary team at any time.

Verbal consent: _____

Representative: _____

Date: _____ Time: _____ Nurse Signature_____

(Put copy in chart and mail to Resident Representative)

Based upon the above information: (Please check one)

[ ] I approve the use of the psychoactive medication and understand the reasons for use with potential risks and benefits.

[ ] I do not approve of the use of the psychoactive medication listed.

_____ _____
Resident/Representative **Date**

_____ _____
Nurse's Signature **Date**