Informed Consent

WARNING:
INCREASED CONFUSION • FALLS • INFECTION
BLOOD CLOTS • STROKE • DEATH

ANTIPSYCHOTICS ARE NOT APPROVED
AS A TREATMENT OF DEMENTIA IN OLDER ADULTS

THE DANGER OF ANTIPSYCHOTICS
While given antipsychotic drugs, older adults with dementia are dying at twice the rate. (Nielsen, 2017)

MISUSE IN NURSING HOMES
1 in 5 nursing home residents is given unnecessary antipsychotic drugs. (Harrington, 2014)

WHO
Only you or the person you choose to act for you may agree to the use of any drug.

WHAT
INFORMED CONSENT
An agreement given or denied by the patient to the doctor, after being fully informed. Informed consent is best in writing. The nursing home’s role is to insure an individual’s consent is given before the drug is used.

HOW
Talk to your physician and pharmacist. Your doctor should discuss and give you in writing a list of all possible risks, benefits, and side-effects. You may agree or decline to use any drug.

KANSAS ADVOCATES for BETTER CARE
making elder care better every day
kabc.org • info@kabc.org • 785-842-3088
Informed Consent for Medication

Completion of this form is voluntary. You may want to use this form to talk with family members, your legal representative, and/or health care providers about your wishes regarding the use of unnecessary drugs or drugs used to chemically restrain you. You may use this form to advise a person acting on your behalf, or a health provider of any steps you want them to take thoroughly considering the use of such drugs prior to consenting to the drug use. You may want to attach the form to your health care power of attorney, advance health care directive, or living will. You may want to share it with your primary care doctor or another health care provider, such as an adult care facility. Visit www.kabc.org

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<tr>
<td>Birthdate:</td>
<td>City, State, Zip:</td>
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<tr>
<td>Designated Rep. for Health Care:</td>
<td>Phone:</td>
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<td>Primary Physician</td>
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*Indicate Medications Below You Prefer Not Be Administered To You

<table>
<thead>
<tr>
<th>Medication Category</th>
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Alternative mode(s) of treatment which may be used and ought to be used before considering use of psychotropic medications. Document any change resulting from use.

- Environment and/or change of caregiver
- Positive redirection & interaction
- Individual and/or group therapy
- Pain Assessment, Pain Medication
- Massage

Things which historically worked for me:
INFORMED CONSENT

To achieve Informed Consent all possible side effects, warnings, and cautions associated with this medication ought to be explained to you. What is shared with you may not be an all-inclusive list but should represent items of potential clinical significance to you. For more information, you may want to refer to a standard text, such as the Physicians Desk Reference/PDR or talk with a geriatric pharmacist.

Informed Consent - information to consider if use of an Anti-Psychotic Medication is being suggested:
- Why/Reason to use Psychotropic Medication. Benefits Expected (is the use ‘Off-Label’ or non-FDA approved). Is there a mental illness diagnosis? Include DSM-5 diagnosis or the diagnostic “working hypothesis.”
- Most Common Side Effects of Medication being considered
- Rare Side Effects
- Caution
- Warning

*See PDR for an all-inclusive list of side effects

I understand the following:
1. I have the right to give or refuse to give consent for any medication. I can withdraw my consent at any time. Initial consent does not affect my right to change my decision at a later date. If I withdraw consent after a medication is started, I realize that the medication may not be discontinued immediately. Rather, it will be tapered as rapidly as medically safe and then discontinued so as to prevent an adverse medical consequence, such as seizures, due to rapid medication withdrawal.
2. I have the right to ask questions regarding this medication which are best discussed with my physician and pharmacist. If I am in a care facility, staff can assist in making any necessary arrangements for discussions.
3. I have the right to discuss any questions regarding any behavioral support plan or behavior intervention plan, which correspond with the use of the medication, with a social worker, case manager, or psychologist who may be assisting me.
4. I have the right to request a review of my health record at any time.
5. I have the right to file a complaint with the Kansas Department of Aging and Disability Services (KDADS) and/or the Long-Term Care Ombudsman if I feel that my rights have been inappropriately restricted by an adult care facility. KDADS 1+800-842-0078. Kansas Long-Term Care Ombudsman 1+877-662-8362, resident advocate. If I live in my own home, I can contact Adult Protective Services if I feel I am medicated against my will. APS 1+(800) 922-5330.
6. I have the right to be fully informed about the following: reasons for the use of any medication, its potential risks and benefits, other alternative treatment(s) or interventions, and the probable consequences that may occur if the proposed medication is not given. I have the right to have adequate time to study the information and find the information to be specific, accurate, and complete, before making any decision.
7. I have the right to define the period of time any consent signed remains in effect.

SIGNATURES

Adult—If presumed Competent or Guardian (POA-HC) Relationship to Adult
  [ ] Self  [ ] Parent  [ ] Guardian (POA-HC)

Witness Present at Oral Discussion  Title

DATE SIGNED