MH 730
Revised 7/1/22

MEDICATION CONSENT

Date: _____

Current Medications:

Medication Consent:

☐ The reasons for taking the medications, including the likelihood of improving or not improving without such medications, were discussed with the client/legal representative and are documented in the Clinical Record.

☐ The dosage, frequency, method of administration and duration of the above medication(s), has been discussed with the client/ legal representative. Any changes in medication dosage and/or frequency during the course of treatment will be discussed with the client/legal representative.

☐ Reasonable alternatives, if any, were discussed with the client/legal representative.

☐ The client/ legal representative has been informed of possible side-effects including those that may be present after 3 months and, if applicable, notified that with some anti-psychotics there is a possible side-effect of tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso and may persist even after stopping the medication.

☐ Written notification (e.g. OrderConnect leaflet) regarding the medication(s) and its side-effects was offered to the client/legal representative.

☐ The client/ legal representative has been notified that he/she should promptly inform his/her treating provider about changes in his/her condition (e.g.. dizziness, severe sedation, rash), if she becomes pregnant, any decision to discontinue a medication and/or if any new medication(s) are prescribed/taken for other conditions.

☐ The client/ legal representative has been informed that he/she may withdraw consent at any time.

☐ If applicable, indicate if the JV 220 was completed and entered in the Clinical Record in addition to this medication consent JV-223 Order Date: _____

Other Medication Consent Comments:

Signatures:

Information provided in: _____ (language)

Client Signature/Legal Rep Signature: _____

Client/Legal Rep unable to sign, but provided verbal consent: ☐ Yes ☐ No

Copy of this form was offered to the client: ☐ Yes ☐ No

MD/NP Signature: _____ **Date:** _____

Name: _____ **DMH ID#:** _____

Agency: _____ **Provider #:** _____

Los Angeles County – Department of Mental Health

MEDICATION CONSENT