

MEDICATION CONSENT AND TREATMENT PLAN

Date: _____

Current Medications:

Medication Consent Section:

- 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: _____

Treatment Plan Section

Objective: Reduce symptoms of as evidenced by

Intervention(s): Medication support services for one year including

- Prescribe medication(s) Monitor clinical effectiveness and side effects
- Medication education Collateral education Administer medications (e.g. injections)

Proposed Frequency of Contact: Weekly Every other week Monthly Every 3 months

Signatures Section

Information provided in: _____ (language)

Client Signature/Legal Rep Signature: _____

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

MD/NP Signature: _____ Date: _____

This confidential information is provided to you in accord with State and Federal laws and regulations including but not limited to applicable Welfare and Institutions code, Civil Code and HIPAA Privacy Standards. Duplication of this information for further disclosure is prohibited without prior written authorization of the client/authorized representative to whom it pertains unless otherwise permitted by law. Destruction of this information is required after the stated purpose of the original request is fulfilled.

Name: _____ DMH ID#: _____
 Agency: _____ Provider #: _____
 Los Angeles County – Department of Mental Health