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:** _____

**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**

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