**DEPARTMENT OF HEALTH SERVICES**
Division of Care and Treatment Services
F-24277 (05/2024)

**STATE OF WISCONSIN**
42 CFR483.420(a)(2)
DHS 134.31(3)(o)
DHS 94.03 & 94.09
§§ 51.61(1)(g) & (h)

# INFORMED CONSENT FOR MEDICATION

**Dosage and / or Side Effect information last revised on 07/13/2020**

Completion of this form is voluntary. If informed consent is not given, the medication cannot be administered without a court order unless in an emergency.
This consent is maintained in the client's record and is accessible to authorized users.

| Name – Patient / Client (Last, First MI) | ID Number | Living Unit | Date of Birth |
|---|---|---|---|
| , | | | |

| Name – Individual Preparing This Form | Name – Staff Contact | Name / Telephone Number – Institution |
|---|---|---|
| | | |

| MEDICATION CATEGORY | MEDICATION | RECOMMENDED DAILY TOTAL DOSAGE RANGE | ANTICIPATED DOSAGE RANGE |
|---|---|---|---|
| Antidepressant | Ludiomil (maprotiline) | 25 mg – 225 mg | |

The anticipated dosage range is to be individualized, may be above or below the recommended range but no medication will be administered without your informed and written consent.
Recommended daily total dosage range of manufacturer, as stated in *Physician's Desk Reference* (PDR) or another standard reference.
This medication will be administered ☐ Orally ☐ Injection ☐ Other – Specify:

**1. Reason for Use of Psychotropic Medication and Benefits Expected (note if this is 'Off-Label' Use)**
Include DSM-5 diagnosis or the diagnostic impression ("working hypothesis.")

**2. Alternative mode(s) of treatment other than OR in addition to medications include**
Note: Some of these would be applicable only in an inpatient environment.

☐ Environment and/or staff changes
☐ Positive redirection and staff interaction
☐ Individual and/or group therapy
☐ Rehabilitation treatments/therapy (OT, PT, AT)
☐ Treatment programs and approaches (habilitation)
☐ Use of behavior intervention techniques

**Other Alternatives**:

**3. Probable consequences of NOT receiving the proposed medication are**

**Impairment of** ☐ Work Activities ☐ Family Relationships ☐ Social Functioning

**Possible increase in symptoms leading to potential**

☐ Use of seclusion or restraint
☐ Limits on access to possessions
☐ Limits on personal freedoms
☐ Limit participation in treatment and activities
☐ Limits on recreation and leisure activities
☐ Intervention of law enforcement authorities
☐ Risk of harm to self or others

**Other Consequences**:

**Note:** These consequences may vary depending upon whether or not the individual is in an inpatient setting. It is also possible that in unusual situations, little or no adverse consequences may occur if the medications are not administered.

See Page 2

Client Initial _____ Date _____

**4.** Possible side effects, warnings, and cautions associated with this medication are listed below. This is not an all-inclusive list but is representative of items of potential clinical significance to you. For more information on this medication, you may consult further with your physician or refer to a standard text, such as the PDR. As part of monitoring some of these potential side effects, your physician may order laboratory or other tests. The treatment team will closely monitor individuals who are unable to readily communicate side effects in order to enhance care and treatment.

Continued – Possible side effects, warnings, and cautions associated with this medication.

**Most Common Side Effects:** rash, redness, swelling, or itching of the skin; blurred vision; decreased sexual ability; dizziness or lightheadedness (especially in the elderly); nervousness; tremor; drowsiness; dry mouth; headache; increased or decreased sexual drive; tiredness or weakness.

**Less Common Side Effects:** constipation (severe); nausea or vomiting; shakiness or trembling; seizures (convulsions); unusual excitement; weight loss; diarrhea; heartburn; increased appetite and weight gain; Fincreased sensitivity of skin to sunlight; increased sweating; trouble with sleeping; weight loss.

**Rare Side Effects:** Although rare, contact your physician if you experience any of the following: breast enlargement—in males and females; confusion (especially in the elderly); difficulty in urinating; fainting; hair loss; severe rash; new or worsening glaucoma; hallucinations (seeing, hearing, or feeling things that are not there); inappropriate secretion of milk—in females; irregular heartbeat (pounding, racing, skipping); sore throat and fever; swelling of testicles; yellow eyes or skin.

**Caution**

- **Alcohol**
  This medicine will add to the effects of alcohol and other CNS depressants.
- **QT prolongation**
  This medication has the potential to prolong the QT interval, and should not be used by those who have congenital long QT syndrome. Additionally, patients should notify their doctor if they are on any other QT prolonging drugs before starting this medication.
- **Vision changes**
  This medicine may cause blurred vision, especially during the first few weeks of treatment. It may also cause some people to become drowsy or less alert than they are normally. If these effects occur, do not drive, use machines, or do anything else that could be dangerous if you are not alert or able to see well.
- **Orthostatic hypotension**
  Dizziness, lightheadedness, or fainting may occur, especially when you get up from a lying or sitting position. Getting up slowly may help. If this problem continues or gets worse, check with your doctor.
- **Surgery precautions**
  Before having any kind of surgery, dental treatment, or emergency treatment, tell the medical doctor or dentist in charge that you are using this medicine.
- **Driving and operating heavy machinery**
  This medication may make you dizzy or drowsy, which can make it dangerous to drive, operate heavy machinery, or do anything else that would be hazardous if not fully alert. Try to avoid these activities until you know how this medication affects you.
- **Seizures**
  This medication may increase the risk of seizures, especially in those with a history of experiencing seizures. Other groups at a higher risk include those with head trauma, brain damage, alcoholism, or concurrent therapy with medications which may lower the seizure threshold. Please report any adverse events to your doctor.
- **Withdrawal**
  Do not suddenly stop taking this medication as to avoid potential withdrawal symptoms. Please speak with your doctor before stopping this medication.

**Warning: [Black Box Warning]: Suicidality and Antidepressant Drugs**
Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in short term studies in children, adolescents, and young adults with major depressive disorder (MDD) and other psychiatric disorders. Anyone considering the use of this drug or any other antidepressant in a child, adolescent, or young adult must balance this risk with the clinical need. Short-term studies did not show an increase in the risk of suicidality with antidepressants compared to placebo in adults beyond age 24; there was a reduction in risk with antidepressants compared to placebo in adults aged 65 and older. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on therapy should be monitored appropriately and observed closely for clinical worsening, suicidality, or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber. Amoxapine is not approved for use in pediatric patients.

MONITORING RECOMMENDATIONS RELATED TO BLACK BOX DATA—Close observation for suicidal thinking or unusual changes in behavior.

These medications could be very dangerous if taken in large doses. Symptoms of overdose include convulsions (seizures); dizziness (severe); drowsiness (severe); fast or irregular heartbeat; fever; muscle stiffness or weakness (severe); restlessness or agitation; trouble in breathing; vomiting.

See standard reference text for an all-inclusive list of side effects.



Client Initial _____ Date _____

Medication : Ludiomil - (maprotiline)

**By my signature below, I GIVE consent for the named medication on Page 1 and anticipated dosage range. My signature also indicates that I understand the following:**

1. I can refuse to give consent or can withdraw my consent at any time with written notification to the institution director or designee. This will 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. Questions regarding this medication can be discussed with the Interdisciplinary Team, including the physician. The staff contact person can assist in making any necessary arrangements.
3. Questions regarding any behavior support plan or behavior intervention plan, which correspond with the use of the medication, can be directed to the client's social worker, case manager, or psychologist.
4. I have the right to request a review at any time of my record, pursuant to § 51.30(4)(d) or § 51.30(5)(b).
5. I have a legal right to file a complaint if I feel that client rights have been inappropriately restricted. The client's social worker, case manager, or agency/facility client rights specialist may be contacted for assistance.
6. My consent permits the dose to be changed within the **anticipated dosage range** without signing another consent.
7. I understand the reasons for the use of the medication, its potential risks and benefits, other alternative treatment(s), and the probable consequences that may occur if the proposed medication is not given. I have been given adequate time to study the information and find the information to be specific, accurate, and complete.
8. This medication consent is for a period effective immediately and not to exceed fifteen (15) months from the date of my signature. The need for and continued use of this medication will be reviewed at least quarterly by the Interdisciplinary Team. The goal, on behalf of the client, will be to arrive at and maintain the client at the minimum effective dose.

| **SIGNATURES** | | **DATE SIGNED** |
|---|---|---|
| Client – If Presumed Competent to Consent/Parent of Minor/Guardian (POA-HC) | Relationship to Client ☐ Self ☐ Parent ☐ Guardian (POA-HC) | |
| Staff Present at Oral Discussion | Title | |

Client / Parent of Minor / Guardian (POA-HC) Comments

**As parent/guardian (POA-HC) was not available for signature, he/she was verbally informed of the information in this consent.**

**Verbal Consent**

| | | |
|---|---|---|
| Obtained by – PRINT – Staff Name | Date Obtained | Written Consent Received ☐ Yes ☐ No |
| Obtained from – PRINT – Parent / Guardian (POA-HC) Name | Date Expires | Date Received |



Client Initial _____ Date _____