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| DEPARTMENT OF HEALTH SERVICES Division of Care and Treatment Services  F-24277 (09/2016) | STATE OF WISCONSIN 42 CFR483.420(a)(2)  DHS 134.31(3)(o)  DHS 94.03 & 94.09  §§ 51.61(1)(g) & (h) |

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| INFORMED CONSENT FOR MEDICATIONDosage and / or Side Effect information last revised on 11/13/2017 Completion of this form is voluntary. If not completed, 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 |
| Antianxiety Agent (benzodiazepine) | Tranxene  (clorazepate) | | | | | 3.75 - 60mg | | |  |
| 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: | | | | | | | | | |
| Reason for Use of Psychotropic Medication and Benefits Expected (note if this is ‘Off-Label’ Use) Include DSM-5 diagnosis or the diagnostic “working hypothesis.” | | | | | | | | | |
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| **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 | | | | Rehabilitation treatments/therapy (OT, PT, AT) | | | | | |
| Positive redirection and staff interaction | | | | Treatment programs and approaches (habilitation) | | | | | |
| Individual and/or group therapy | | | | Use of behavior intervention techniques | | | | | |
| **Other Alternatives**: | | | | | | | | | |
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| 3. Probable consequences of NOT receiving the proposed medication are | | | | | | | | | |
| Impairment of  Work Activities | | Family Relationships | | | | | Social Functioning | | |
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| Possible increase in symptoms leading to potential | | | |  | | | | | |
| Use of seclusion or restraint | | | | Limits on recreation and leisure activities | | | | | |
| Limits on access to possessions | | | | Intervention of law enforcement authorities | | | | | |
| Limits on personal freedoms | | | | Risk of harm to self or others | | | | | |
| Limit participation in treatment and activities | | | |  | | | | | |
| **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

| F-24277 | Medication: Tranxene – (clorazepate) |
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| 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 The Most common side effects include drowsiness, dizziness. | |
| **Less Common Side Effects**  Less Common side effects include various gastrointestinal complaints, nervousness, blurred vision, dry mouth, headache, and mental confusion. | |
| **Rare Side Effects**  Rare side effects include insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, tremor, and slurred speech. There have been reports of abnormal liver and kidney function tests and of decrease in hematocrit. Decrease in systolic blood pressure has been observed. | |
| **BLACK BOX WARNING**  **Risks from concomitant use with opioids:**  Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of these drugs for use in patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation.  **WARNINGS**  **Use in Depressive Neuroses or Psychotic Reactions:**  Clorazepate is not recommended for use in depressive neuroses or in psychotic reactions  **Use in Children:**  Because of the lack of sufficient clinical experience, Clorazepate is not recommended for use in patients less than 9 years of age.  **Interference with Psychomotor Performance:**  Patients taking clorazepate should be cautioned against engaging in hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles.  **Physical and Psychological Dependence:**  Withdrawal symptoms (similar in character to those noted with barbiturates and alcohol) have occurred following abrupt discontinuance of clorazepate. Withdrawal symptoms associated with the abrupt discontinuation of benzodiazepines have included convulsions, delirium, tremor, abdominal and muscle cramps, vomiting, sweating, nervousness, insomnia, irritability, diarrhea, and memory impairment. The more severe withdrawal symptoms have usually been limited to those patients who had received excessive doses over an extended period of time. Generally milder withdrawal symptoms have been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Consequently, after extended therapy, abrupt discontinuation of clorazepate should generally be avoided and a gradual dosage tapering schedule followed.  Caution should be observed in patients who are considered to have a psychological potential for drug dependence.  Evidence of drug dependence has been observed in dogs and rabbits which was characterized by convulsive seizures when the drug was abruptly withdrawn or the dose was reduced; the syndrome in dogs could be abolished by administration of clorazepate.  **Suicidal Behavior and Ideation:**  Antiepileptic drugs (AEDs), including Clorazepate, increase the risk of suicidal thoughts or behavior in patients taking these drugs for any indication. Patients treated with any AED for any indication should be monitored for the emergence or worsening of depression, suicidal thoughts or behavior, and/or any unusual changes in mood or behavior.  In those patients in which a degree of depression accompanies the anxiety, suicidal tendencies may be present and protective measures may be required. The least amount of drug that is feasible should be available to the patient.  **Usage during Lactation:**  Clorazepate should not be given to nursing mothers since it has been reported that nordiazepam is excreted in human breast milk. | |
| See PDR for an all-inclusive list of side effects. | |
| 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. | |

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| **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 | |