

MRN: \_\_\_\_\_ Gender:  Male  Female

Name: \_\_\_\_\_

Adm.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Doctor: \_\_\_\_\_

## CONSENT FOR THE USE OF PSYCHOTROPIC MEDICATION

I, \_\_\_\_\_, have been informed by Dr. \_\_\_\_\_

(print name)

designee, that the medications listed below or similar medication(s) is/are prescribed for myself/my child/me legal ward's treatment. I have been given written and/or verbally information about the use, precautions and possible side effects, and I have had the opportunity to discuss this and other available treatment alternatives with the prescribing doctor.

As the patient/parent/legal guardian, I understand the information provided, and after discussion with the physician, consent to have this drug administered. I understand that I may change my mind at any time and no guarantee has been given to me of the results that may be obtained by consenting to medication use.

Medication: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I have offered the patient an opportunity for further explanation of this drug and its side effects.

M.D., R.Ph., R.N. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 I received verbal consent from the parent/legal guardian on \_\_\_\_\_

Medication: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I have offered the patient an opportunity for further explanation of this drug and its side effects.

M.D., R.Ph., R.N. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 I received verbal consent from the parent/legal guardian on \_\_\_\_\_

Medication: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I have offered the patient an opportunity for further explanation of this drug and its side effects.

M.D., R.Ph., R.N. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 I received verbal consent from the parent/legal guardian on \_\_\_\_\_

Medication: \_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

I have offered the patient an opportunity for further explanation of this drug and its side effects.

M.D., R.Ph., R.N. Signature: \_\_\_\_\_ Date: \_\_\_\_\_

 I received verbal consent from the parent/legal guardian on \_\_\_\_\_*With the use of Neuroleptics the following additional concerns exist:*

I have been told that a potentially severe and possibly irreversible side effect of the medication is Tardive Dyskinesia. Although this condition may occur with short-term administration or after discontinuation of this medication, it is more likely to occur with long-term use. It appears as slow involuntary movements of the nose, tongue, mouth or face and sometimes other parts of the body. The movements are writhing, purposeless, occasionally irregular and may or may not be continuous. Sucking, licking, lip pursing, blowing and chewing movements are commonly seen. Not all such movements are drug-induced.

## PATIENT PERSONAL PROPERTY LOG

P = Items kept by patient

L = Items place in locker

QTY		P	L	QTY		P	L
	<b>CLOTHING</b>				<b>PERSONAL HYGIENE:</b>		
	Belt				Deodorant		
	Blouse				Toothpaste		
	Boots				Wigs		
	Brassiere				Shampoo		
	Cap/Hat(s) (circle)				Toothbrush		
	Coat				Hair Gel/Oil		
	Dresses				<b>MEDICAL EQUIPMENT:</b>		
	Gloves				Wheelchair		
	Gowns				Walker		
	Jacket(s)				Crutches		
	Pajamas				Hearing Aid		
	Underwear				Dentures		
	Describe:				Canes		
	Socks				<b>SHARPS</b>		
	Pants/Slacks				Razors		
	Purse				a) Electric		
	Robe				b) Disposable		
	Scarf				Scissors		
	Shirt(s)				Knife		
	Shoes				Tweezers		
	Short(s)				Dentures		
	Slippers				Eyeglasses/Sunglasses/Contact Lens		
	Sweater				Luggage/Back pack		
<b>All items listed in this area must be placed in the SAFE</b>							
<b>Jewelry (value less than \$100 with description)</b>			<b>Jewelry (value over \$100 with description)</b>			<b>Credit Card(s)</b>	
	Description	Value		Description	Value		
	Bracelet			Bracelet			
	Earring			Earring			
	Necklace			Necklace			
	Ring			Ring			<b>Identification Card(s)</b>
	Watch			Watch			
<b>Electronic Equipment</b>							
Cell Phone (Brand)			Radio			Other	
IPOD			Other			Other	
<b>Money/Checks (List the denomination of current and individual checks)</b>							

By giving BCA my personal items for storing, I agree to the terms of this agreement and also agree to the terms on the behalf of any 3rd party who has an interest in these items. I understand that BCA is not responsible for items kept in my possession. Any item valued over \$100 has been identified on this form. Failure to declare a value for item(s) over \$100 may result in an assessed value based on BCA's best estimate.

In any case, BCA's liability will not exceed \$400 for the total contents left in their possession except for cash declared and valued at face value.

Do you wish a copy sent to another individual? [ ] Y [ ] N

Staff Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_ Patient's Witness Signature: \_\_\_\_\_ Date/Time: \_\_\_\_\_

Property Returned Patient Signature: \_\_\_\_\_ Date Witness By StoneCrest Staff Signature: \_\_\_\_\_

### Medical Diagnosis Checklist

Medical conditions listed below were reviewed and documented by a member of the clinical staff - Nurse Supervisor (RN), a Registered Nurse, the Attending Physician, and/or the facility's Medical Director prior to patient's admission to the facility.

<b>Diabetes</b>	Normal Blood Sugar Level: (Must be below 180) _____ N/A _____ Current Blood Sugar Level: _____ Date & Time _____
<b>Seizure Disorders</b>	Date of Last Seizure: _____
<b>Hypertension</b>	Current Blood Pressure: _____ Date & Time _____ N/A _____
<b>Blood Alcohol Substance Abuse</b>	Current Blood Alcohol Level: _____ Date & Time _____ Repeat Blood Alcohol Level: _____ Date & Time _____ N/A _____
<b>Physical Examination</b>	Patient was Medically Cleared prior to Admission: Yes _____ No _____ N/A _____ Date of Last Physical Exam: _____
<b>Hematology/Oncology</b>	Anemia: Female: Hgb less than 10 - Male: Hgb less than 12 Bleeding Disorder _____ Sickle Cell Anemia Disease _____ N/A _____
<b>Neurology</b>	Dementia _____ Traumatic Brain Injury - TBI _____ (Closed Head Injury - CHI) _____ N/A _____
<b>Pulmonary</b>	Asthma/Bronchitis _____ N/A _____ Pulse oxygen less than 96% _____ Nebulizer _____ Last attack 2 days or less _____ ICU Admits _____ Pneumonia _____ COPD _____
<b>Infectious Disease</b>	Tuberculosis - TB _____ LICE _____ SCABIES _____ N/A _____
<b>Surgery</b>	Surgery within last 2 months or less _____ Replacement Surgery within last 2 months or less _____ Fractures within last 6 weeks _____ N/A _____
<b>Pregnancy</b>	Months: _____ Delivery Date: _____ Complications: _____ Pregnancy Test: Yes / No _____ Results: + / - _____ Hysterectomy: Yes / No _____ LMP _____
<b>Special Diets</b>	Diabetic _____ Pureed _____ Mech Soft _____ Thickened Liquids _____ N/A _____
<b>HIV</b>	Diagnosis Length _____ Medication Available: Yes / No _____ Compliant w/meds : Yes / No _____ Medical Complications _____ Height _____ Weight _____ Substance Abuse Yes / No _____ Recent weight loss Yes / No _____ Any previous Psychiatric Admissions _____ # _____ Date of last Admission: _____ Outpatient: _____
<b>Comments</b>	

Patient presented with no medical complications.

Admission Coordinator: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_  
Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_