Program Review Committee Consent for Treatment

**Psychiatric Medication**  **Aversive Program**  **Pre-sedation Medication**

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| --- | --- | --- | --- |
| Name | DDS # | | DOB      /     / |
| Address | | Agency/Facility | |
| Medication Name | | | |
| Dosage Range From       To | | | |
| Medication Side Effects (    See Attached or      See Description Below) | | | |
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| **Additional Behavior Modifying Medications Currently Prescribed?**     **Yes**    **No** Rationale for Treatment | | | |
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| Treatment Plan Reassessment Frequency | | | |
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|  | | | |
| Description of Aversive Program (    See Attached or      See Description Below) | | | |
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I understand the risks involved with this treatment plan as compared to the risks involved with not implementing this plan and I have received an explanation of available alternatives.

I understand that I have the right to confer with any professionals or authorities that I choose before giving my consent to the implementation of this treatment plan. I further understand that I have the right to have any questions about this plan answered to my satisfaction and that I may withdraw my consent for this plan at any time.

I have been informed of my right to request a Programmatic Administrative Review in accordance with DDS policy.

**Signatures**

## Individual \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      /     /

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**Legal Representative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**      /     /

**Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**      /     /

**Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**      /     /     