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) |
|       |
|       |
|       |
|       |
| **Additional Behavior Modifying Medications Currently Prescribed?** **[ ]**     **Yes**    **[ ] No**Rationale for Treatment |
|       |
|       |
|       |
|       |
| Treatment Plan Reassessment Frequency |
|       |
|       |
|       |
|       |
| Description of Aversive Program (    See Attached or      See Description Below) |
|       |
|       |
|       |
|       |

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:      /     /

##

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

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

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