Connecticut Department of Developmental Services

HRC Consent for Treatment for Pre-Sedation

Psychotropic Medication Restrictive Program Pre-sedation Medication

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 Restrictive 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:

Consumer: _____ Date: / /

Legal Guardian: _____ Date: / /

Witness: _____ Date: / /

Witness: _____ Date: / /