Client Name:		**Destiny Management**
Record #:	**Medicaid #:**	**Informed Consent - Medical**

Notes:
1. Medication education received from the pharmacist/physician must be attached for **each prescription** medication for which consent is being obtained.
2. Consent must be obtained prior to administering a **prescription** medication. Consent can be obtained verbally and documented on this form; however, written consent must also be obtained from the Legally Responsible Person and documented on this consent form.
3. Clients who self-medicate must receive medication education **prior to** self administering new medications.

Medication(s): _____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

I have been informed in detail of the medication(s) that has been prescribed; the reasons why the medication(s) was prescribed; the strength of the drug(s), and the potential benefits as well as the potential side effects of the medication(s). I am aware of the risks and consequences as well as the expected results of taking this medication(s). I have had the opportunity to ask questions and receive answers regarding this medication(s).

Please check one of the following:

☐ I have taken all of this information into consideration and consent to the use of the medication(s).

☐ I have taken all of this information into consideration and do not consent to receiving the medication(s). I am requesting an alternative treatment be made available which is comparable to the treatment recommended. I understand punitive actions will not being taken against me because I do not consent to the treatment offered.

I understand that if an alternative treatment(s) is offered and refused or if no alternative treatment **exists** to the treatment refused, the agency must consider the effect this refusal may have on the individual him or herself, other individuals, and the agency. The agency must consider whether it can continue to provide services in compliance with regulatory requirements.

Consent Start Date: _____
Consent End Date: _____ (Cannot exceed six months)

REVOCATION AND EXPIRATION
I understand that, with certain exceptions I have the right to revoke this authorization at any time. (**If I want to revoke this authorization, I must do so in writing.**) The consent is subject to revocation at any time except to the extent that action has been taken in reliance on the consent. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke, are explained in Destiny Management's Notice of Privacy Practices, a copy of which has been provided to me.

Verbal consent obtained by (Employee Name): ________________________________ Date:__________ ☐ N/A

Legally Responsible Person's Signature: ______________________________ Date:____________

Client's Signature ______________________________ Date:____________

The client must sign the consent if they are authorized to self-medicate.