CCS: INFORMED CONSENT – MEDICATION(S)

Client Name ______________________________ DOB___________ Case #___________________

I/my child am/is a patient of the CCS physician/nurse practitioner who recommends that I/my child receive medication(s) for the treatment of my/my child's psychiatric and/or behavioral problems, in addition to other mental health services.

The physician/nurse practitioner has informed of the nature of the treatment and has explained to me the rationale, benefits, contraindications, and possible risks and side effects, including risks associated with pregnancy. The physician/nurse practitioner has also informed me of the need for any laboratory monitoring.

A. **If the prescribed medication is a neuroleptic, I have been informed of the risk of Tardive Dyskinesia, which may cause involuntary tic-like movements in the face, tongue, neck, arms, and/or legs which may persist even after the medication treatment is terminated.**

B. **If the prescribed medication is Trazadone, I have been informed of the risk of Priapism.**

C. **If the prescribed medication is a stimulant, I have been informed of tics, which are sudden, rapid, recurrent, nonrhythmic, stereotyped motor movements, or vocalizations. These tics may persist even after the medication is terminated.**

D. **If the prescribed medication is an atypical neuroleptic, like Zyprexa, Clozaril, Risperdal, Seroquel, Geodon, or Abilify, I have been informed of the possibility of developing or exacerbating hyperglycemia and/or diabetes.**

I have been informed of potential implications between the prescribed meds and diet/exercise, as well as special dietary needs and restrictions associated with the prescribed meds. I have been made aware of early signs of relapse or nonadherence to prescribed meds, e.g., worsening mood or behaviors. I have been informed of potential drug reactions when combining prescribed meds to non-prescribed meds, drugs, alcohol, tobacco, caffeine, illegal drugs, and/or alternative medicines. I have been given instructions on how to self-administer the medication, if applicable.

I have been informed that some/all of these medications may not be approved by the FDA for children/adolescents/ adults. Some/all of the medications may not be approved by the FDA for the condition(s) I/my child have/has. I understand that, although the physician/nurse practitioner has explained to me the most common side effects of this treatment, there may be other side effects, and that I should promptly inform the physician/nurse practitioner or a member of the clinical staff at Churchill Counseling if there are any unexpected changes in my/my child's condition.

I understand that I/my child am/is not compelled to take the medication(s) and that I may decide to stop taking the medication(s) at any time. If I do choose to stop taking the medication(s), I am obligated to inform the physician, nurse practitioner, or a member of the clinical staff at Churchill Counseling. I understand that there is no guarantee that this medication(s) will achieve the expected results. I have also received information about the importance of taking the medication as prescribed, potential obstacles to adherence, and alternatives to the medication(s).

As part of my wellness management and recovery planning, I will follow my treatment plan and be kept informed of the progress of my treatment. I understand that if I consent to this medication, the dosage range may not be increased or changed without my further verbal agreement. I have been informed that many drug companies offer financial assistance, and I may obtain this information upon request.

Based on the information provided:

___ I authorize the physician/nurse practitioner to prescribe medication(s) to me/my child.

___ I refuse the medication(s) prescribed. Reason for refusal______________________________

______________________________________ ____________________

Client Signature **Date**

______________________________________ ____________________

Parent/Legal Guardian Signature **Date**

______________________________________ ____________________

Physician/Nurse Practitioner Signature **Date**

Dear Client,

Taking pain medications with opiates (Valium, Ativan, Klonopin, and Xanax) can be dangerous and should be done with caution. Using these medications together may result in decreased respirations (breathing), low blood pressure, profound sedation, and even coma or death. If using these medications together is clinically necessary, you must consider decreasing the dosage of one or both medications to ensure your safety. Please discuss this with your prescriber.

Your prescriber will educate you on the definition and proper usage of PRN Medications. PRN meaning "when necessary," for an occasional or a circumstance that has arisen, such as increased anxiety.

If you are planning to get pregnant in the next 3 months please let your prescriber know of your plans and discuss it with them. You may have to come off of your medications in order to have a safe pregnancy.

Please sign below stating that you understand the above statement.

______________________________ ______________________________

Client Signature Date

______________________________ ______________________________

Doctor/Nurse Practitioner Signature Date

Client name________________________________ Date____________

Please List Your Preferred Pharmacies Below That You Are Currently Receiving Medication From

Please Let Us Know If Your Pharmacy Changes

Pharmacy	Address/City	Phone Number

Churchill Counseling Treatment Plan
Client Consent

Client Name ______________________________

[ ] Informed Consent for Treatment: I am aware of the risks and benefits of my personal treatment plan, alternative treatments, and estimated length of treatment for my diagnosis. I am also aware of the implications and potential consequences of refusing or withdrawing consent for treatment. My signature here documents my consent for treatment.

[ ] I refuse the proposed treatment plan or am withdrawing from treatment here. The therapist explained alternative services available, and I understand the implications and potential consequences of refusing or withdrawing consent for treatment.

[ ] Transition Planning/Take-Home Strategies Form given to client.

[ ] Clients Rights were Reviewed.

______________________________ ____________
Client Date

______________________________ ____________
Parent/Guardian Date

______________________________ ____________
Provider Date

______________________________ ____________
Supervisor Date

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness	○	○

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:______________________________ DATE:______________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns	+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ________
	Somewhat difficult ________
	Very difficult ________
	Extremely difficult ________

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all __________
Somewhat difficult __________
Very difficult ______________
Extremely difficult __________

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.