Informed Consent for Psychotropic Medications for LPS Conservatees

This form meets all requirements for informed consent for LPS clients under the Welfare and Institutions Code Section 5326.2 and 5152 (c). Persons conserved under the LPS Act by definition are not legally capable of making informed treatment decisions for the mental disorder responsible for his/her condition of grave disability. **Please note**: This authorization is only for the treatment of the mental disorder responsible for the conservatee's condition of grave disability. Conservatees retain the right to give or withhold consent to medical care unrelated to the grave disability. At no time shall this authorization be used by the PG office to authorize or consent to medical care for the LPS conservatee. This form is used with the completed and signed Authorization to Detain and Treat form (56-19-075). PLEASE NOTE: CONSENT ENDS at TIME of DISCHARGE

During business hours Monday – Friday 8am-5pm

1. **Complete all sections of the form**
2. **Fax the form to 805-650-1344**
3. **The PAPG office will send authority to treat letter and letters of conservatorship (if needed)**

After hours: Monday - Friday 5pm-8pm; Weekends and holidays 8am-8pm

1. **Complete all sections of the form**
2. **Fax the form to 805-658-4531**
3. **Call the after-hours Manager at 805-701-4535 or 805-290-9080 to review the form and receive verbal authorization to treat. Authority to Detain and Treat form and Letters of Conservatorship (if needed) will be faxed the next business day.**

Name of Sender_____ **Phone Number of Sender** _____

Name of Client _____

Diagnosis or target symptoms _____

Medication	**Initial Dose and Frequency**	**Daily Range**

Complete for each medication proposed

1. If patient information/product information sheet is not attached or previously provided, please describe risk/side effects and benefits of the proposed medication treatment?

☐ Product Information Previously Submitted

_____

_____

_____

_____

_____

_____

_____

2. Please describe potentially fatal side effects/irreversible side effects and plan to manage or mitigate:

☐ Not Applicable

_____

_____

_____

3. Have you considered alternative treatment? ☐ Yes ☐ No

3a. Describe the reasons to use the proposed treatment instead of an alternative or no treatment

_____

_____

4. Which if any proposed medications are considered by the FDA as off-label?

_____

_____

5. **Female clients only**: Is the client pregnant? ☐ Yes ☐ No ☐ Unknown

Answer a) and b) only if client is pregnant

a) What are the risks to the fetus from the proposed medication?

_____

_____

_____

b) Are there alternative medications that could be used to avoid potentially poor outcomes to the fetus?

☐ Yes ☐ No

Describe why these are not considered appropriate

_____

_____

6. If the proposed medication includes Clozaril®, what is the plan for ongoing lab work?

_____

_____

_____

_____ _____

SIGNATURE of PHYSICIAN or Nurse Designee Date

Authority to Detain and Treat form: To be completed by PAPG Office

☐ Authority to Detain and Treat provided to: _____
(Name of person at facility/hospital)

☐ Authority to Detain and Treat denied

Reasons for denial: _____

_____

_____

_____

_____

Name of PAPG staff: _____

Signature of PAPG staff: _____

Date: _____

Time: _____