State of Illinois
Department of Human Services

CONSENT TO MEDICATION

405 ILCS 5/2-107, 2-107.1

NOTICE TO INDIVIDUAL: PLEASE READ THIS CAREFULLY AND ASK QUESTIONS IF YOU DO NOT UNDERSTAND ANY PART OF IT.

MEDICATION COUNSELING

I have been told about and have been given written information about the following recommended medicine(s):

RECOMMENDED MEDICINE(S)
(include dosage range for each)

I understand that the dosage of the medicine(s) may change based on my condition. The physician has talked with me about the following:

* what medicine(s) I will be taking;
* what the medicine(s) are intended to do for me;
* whether the medicine(s) chosen for me requires periodic blood testing;
* the possible side effects of the medicine(s). If the medicine(s) I will be taking can cause tardive dyskinesia, the physician has explained this side effect to me;
* any food-drug interactions which may occur with the medicine(s)
* other treatments and their effectiveness, availability and risks; and
* the availability of a pharmacist to counsel me about any medicine(s) the doctor orders at this time of discharge.

I understand that I have a right to refuse to take medicine(s) and what can happen if I refuse.

CONSENT

☐ I agree to take the medicine(s) listed above.

☐ I do not agree to take the medicine(s) listed above. If my refusal to take medicine(s) results in my being in imminent danger to myself or others, I understand that I may be given medicine(s) under emergency conditions which must be re-evaluated at least every 24 hours. I also understand that a court order may be sought to give me medicine(s). If there is a court order, I understand that the medicine(s) will be given to me over my refusal.

I UNDERSTAND THAT THIS CONSENT IS VALID UNTIL _____ . I UNDERSTAND THE CONSENT
(Calendar date no longer than one year)

IS ONLY GOOD FOR THE MEDICINE(S) LISTED ON THIS FORM. I ALSO UNDERSTAND THAT I CAN REVOKE THIS CONSENT AT ANY TIME.

_____ M.D.
Physician's signature

_____
Date:

_____
Time:

_____
Individual's signature

_____
Guardian's signature (if applicable)

☐ Check here if individual gives verbal consent but refuses to sign

_____
Witness' signature (required for verbal consents only)

Individual _____
Date of Birth: _____ Sex: _____
Identification Number: _____
Facility: _____
Subunit: _____

Reset Form Print Form