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

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

	Medication	Dosage Range/day		Medication	Dosage Range/day
1			5		
2			6		
3			7		
4			8		

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.

Written information regarding the above named medication has been provided and discussed.

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.

☐ The client was examined and has the current capacity to make informed decisions regarding treatment.

_____
Physician's/Prescribing Clinician's Signature

_____ _____
Date: Time:

_____
Individual's signature

_____
Guardian's signature (if applicable)

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

_____
Witness' signature (required for verbal consents only)

Name: _____

Date of Birth: _____ Sex: _____

DMHDD ID#: _____ Unit: _____

Facility: _____