**OKLAHOMA DEPARTMENT OF CORRECTIONS**
**INFORMED CONSENT**
(Neuroleptics)

Facility: _____

***MEDICATION***

☐ Thorazine ☐ Mellaril ☐ Geodon ☐ Prolixin ☐ Loxitane ☐ Risperdal ☐ Navane

☐ Seroquel ☐ Stelazine ☐ Haldol ☐ Other: _____

***PURPOSE***
These medications are used to treat serious emotional and mental conditions, and to restore calmness. They work by improving the balance of chemical substances within the brain.

***COMMON SIDE EFFECTS***
Common side effects include sleepiness, blurred vision, constipation, muscle stiffness, dry mouth, rash, lightheadedness, diarrhea, headache, weight gain, and abnormal involuntary movements, some of which may be persistent and are called "Tardive Dyskinesia" (TD). Your provider will examine you for the development of TD by performing an "Abnormal Involuntary Movement Scale (AIMS)" test every three months. If you experience any of these side effects listed, please report them to any member of the health care staff.

***ALTERNATIVE TREATMENTS***
It has been determined at this time that this category of medication is one of the most effective therapies available, and this class of medication will relieve undesirable symptoms better and more quickly than other treatments. Other treatments include "Talk Therapy" such as counseling or behavior therapy.

***APPROXIMATE LENGTH OF CARE***
The medication usually acts within a few days, and a significant benefit may occur within three weeks. Maximum benefits may require regular usage. The doctor will adjust the dosage from time to time, in most cases, to the minimum dosage that meets the needs of the inmate. The doctor may order laboratory tests from time to time to ensure that the medication is safe.

***RISKS AND HAZARDS***
Avoid alcohol and operating a motor vehicle or other activities that require alertness. Avoid excessive exposure to sunlight. Sudden discontinuation of this medication may cause medical problems.

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***NOTIFICATION***
I understand that I can decide to stop taking this medication at any time by telling the provider or any health care staff. If I decide to stop taking the medication, it will not affect my ability to receive other health care.

I understand that by signing this form I am agreeing to let the provider treat me with a psychotropic drug. The provider has explained the nature of this treatment and the reasons I am being treated. I have also been informed about alternative treatment, the risks and hazards associated with this treatment and the possible side effects I may experience from this treatment. I understand that I can discuss any other questions I might have about my treatment and the provider and that a signed copy of this form will be given to me upon request.

_____ _____
Inmate signature/ODOC # Date

_____ _____
QMHP Signature Date