Chemical/Medication Support(S) for Medical Appointments or Interventions

In order to ensure the health and safety of ________________________________, it has been determined that he/she will require ________________________________, an oral chemical/medication, prior to his/her appointment (dental, imaging, vision, lab, EKG, GYN) or _________.

(Circle one or more)                (Type)

In the past, this person has displayed extreme anxiety/unmanageable behaviors which led to an inability to attend an appointment, participate in a medical procedure or planned event. Despite verbal reassurance, desensitization techniques and/or relaxation methods, anxiety/unmanageable behaviors remain.

Dr. __________________________ has recommended the lowest effective dosage of medication and, along with the team, has decided that the outcome outweighs the possible side effects of the medication in order to best serve this person.

Was physician’s order obtained? Yes ________  No _________

List or attach potential side effects of medication ordered for, but not limited to, sedation:

__________________________________________________________

__________________________________________________________

SIGNATURE OF LHCP: __________________________ Date: __________________________

TEAM APPROVAL: Team members have been contacted and are in agreement with the chemical/medication support(s) being administered to ____________________ and will re-evaluate the continuation of sedation as necessary. The names and dates listed below indicate agreement:

Team Member: __________________________

________________________________________

________________________________________

LEGAL GUARDIAN’S APPROVAL: __________________________ DATE: ______________

CHAIR, HRASC APPROVAL: __________________________ DATE: ______________

RESIDENT’S APPROVAL: __________________________ DATE: ______________

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