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| AUTHORIZATION FOR MEDICATION AND TREATMENT ADMINISTRATION  |
| Name: Date of birth:  |
| If responsibility for medication and treatment administration has been assigned to this company in the *Coordinated Service and Support Plan* and/or *Coordinated Service and Support Plan Addendum*, the company will obtain written authorization from the person served and/or legal representative prior to the administration of any medication or treatment.I authorize the companyto administer the following:

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| [ ]  Routine prescribed medications | [ ]  Prescribed psychotropic medication |
| [ ]  Routine prescribed treatments | [ ]  Prescribed PRN psychotropic medication |
| [ ]  Standing Order Medications (as authorized by prescriber) | [ ]  Other, please specify: |

Please describe any limitations, if any, to the above checked boxes: **I understand the following:*** I may refuse to authorize the company to administer medication or treatment and that the company will not administer the medication.
* This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.
* The company must notify the prescriber as expediently as possible if I refuse to authorize the administration of medication or treatment and any directives or orders given will be followed.
* A refusal to authorize the administration of a specific psychotropic medication is not grounds for service termination and does not constitute an emergency. A refusal to administer the psychotropic medication may not be overridden without a court order.

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