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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:   |  |  | | --- | --- | | 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 * This authorization will remain in effect unless withdrawn in writing and it may be withdrawn at any time.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.   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Person served and/or legal representative Date |