TREASURE COAST Primary Care

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HIGH RISK MEDICATION CONSENT

PATIENT AUTHORIZATION AND NOTICE FOR PATIENTS 65 YEARS AND OLDER

I, _____ understand that the medication that is being prescribed to me has been classified as a high risk medication in the elderly (age 65 and over). This is due to changes in how the body is able to break down some of the medications and due to some changes that occur with aging. Some of these risks include but are not limited to: increased risk of falling, increased risk of dementia, confusion, weakness, urinary retention (being unable to urinate) as well as other risks. I am willing to accept all risks and request that the health care provider continue to provide it for me.

_____ _____

Patient Signature Witness

_____

Date