WRITTEN PATIENT CONSENT FORM
INITIATION OF TEMAZEPAM FOR NIGHT SEDATION IN ADULTS

The use of sleep medicines such as temazepam, a benzodiazepine, for sleep disturbance or insomnia during hospitalisation carries significant potential for harm with little gain in sleep quality and quantity. Poorer sleep than normal is to be expected in hospital. Non-drug therapy including sleep hygiene measures is the most effective safe treatment for sleep disturbance or insomnia.

This consent form is to ensure that the patient is informed and understands the potential negative consequences of temazepam use. The patient (and/or person responsible) should also receive information about temazepam and sleeping in hospital (booklet) including useful **sleep hygiene measures before signing this consent form.**

PATIENT CONSENT

By signing this form, I ______________________________ understand that:

(write name of patient / person responsible)

- I /the person I am responsible for will also use sleep hygiene measures to promote sleep during the hospital stay;
- there are no guarantees that temazepam will improve the quantity or quality of sleep during the hospital stay;
- temazepam may cause serious side effects in me/the person I am responsible for including muscle weakness such as falls and fractures, confusion and agitation, short term memory loss, poorer breathing and incontinence and longer hospital stay;
- use of temazepam for more than a few weeks can lead to dependence and cause unwanted effects such as anxiety or sleeplessness if not stopped carefully;
- temazepam will be used at the lowest possible dose for the shortest possible time only when required;
- temazepam may be stopped or the dose reduced during the hospital stay if it is causing harm or is ineffective; and,
- temazepam will not be prescribed for me/the person I am responsible for when leaving this hospital.

I confirm that I have had the opportunity to ask questions and I am satisfied with the explanation and the answers to my questions.

I understand that I can change my mind and withdraw my consent to being treated with temazepam at any time.

With this knowledge, I **consent** to the use of temazepam in the treatment of me/the person I am responsible for.

Patient's name: ______________________________ **MRN:** ____________ **Age:** ______

Signature of patient (or person responsible*): ______________________________ **Date:** ____/____/____

If applicable, name & signature of witness: ______________________________ **Date:** ____/____/____

Witness is not to be a member of the treating team. In the event that an interpreter is used, the interpreter may not act as a witness to the consent process. Witness must be 18 years or older.

*If the person responsible has signed, please provide details below:

Name: ______________________________ **Date of Birth:** ____/____/____

Address: ______________________________ **Contact Number:** ____________

Relationship to patient: ____________ **Reason for representation:** ____________

DOCTOR'S DECLARATION

☐ I have provided to the patient/their person responsible an explanation of the use of temazepam, its potential benefits and harms and the relevant written patient information. I believe the information has been understood.

Please print & sign this form and file with the patients' Health Record.

Doctors name & designation: ______________________________

Signature: ____________________ **Date:** ____/____/____

If the patient cannot converse adequately in English, please use an accredited Health Care interpreter. Do not rely on relatives or other parties for interpreting.

Language: ____________________ **Name of interpreter & ID #:** ____________________

Signature: ____________________ **Date:** ____/____/____

Completed signed form should be kept in the patient's Health Record.

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