PSYCHOTROPIC MEDICATION INFORMED CONSENT

NEBRASKA DEPARTMENT OF HEALTH and HUMAN SERVICES

SECTION A	PSYCHOTROPIC MEDICATION RECOMMENDATION: (to be completed by licensed medical professional)											
Name:						Date of Visit:						
Gender:	Female:		Male:		DOB:			Age:				
Height:		Weight:		Blood Pressure:			Pulse:					
Prescribing Provider's Name:								Telephone Number:				
Facility/Office Name:				Facility/Office Address:								
Clinical Information												
Mental Health Diagnosis:												
Concurrent Medical Diagnosis (physical health):												
Current Psychotropic Medications												
Medication/Dosage Administration Schedule			INDICATION			START DATE /PRESCRIBER						
Discontinued Psychotropic Medication (s) and Reason for Discontinuation:												
New Psychotropic Medications and Recommendations (not necessary for dosage changes within current prescribed medications)												
Name of Medication #1:				Dosage Range:			Frequency:					
Target Symptoms/Benefits:				Potential Side Effects:								
Rationale:												
Tests/Procedures required before, during & after medication regimen:				Alternative Treatments:								
Name of Medication #2:				Dosage Range:			Frequency:					

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Target Symptoms/Benefits:			Potential Side Effects:				
Rationale:							
Tests/Procedures required before, during & after medication regimen:			Alternative Treatments:				
Name of Medication #3: **(use another DHR/SSA-631-G form for 3 or more medications)**			Dosage Range:		Frequency:		
Target Symptoms/Benefits:			Potential Side Effects:				
Rationale:							
Tests/Procedures required before, during & after medication regimen:			Alternative Treatments:				
Reviewed All Above Information							
With Youth	Yes:	No:	With foster parent /current foster placement	Yes:	No:	Foster Parent's Name:	
Foster Care Case Worker	Yes:	No:	Foster Care Case Worker's Name:			Foster Care Case Worker's Phone Number:	
Child Psychiatrist (**Complete if prescribing clinician is not a child psychiatrist)**			Yes:	No:	Child Psychiatrist's Name:	Child Psychiatrist's Phone Number	
SECTION B	**NOTIFICATION (to be completed by foster case worker)**						
Child Name:			DOB:		Legal Status:	Case #:	

Legal parent (s) were notified of psychotropic medications ☐ Yes ☐ No

Child is in state custody ☐ Yes ☐ No

For children that are in temporary custody, medications cannot be administered until signed consent is received from parent/legal guardian or the court.

Comments:

Foster Care Case Worker's Name:	Jurisdiction:
LDSS Address:	Phone Number:

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SECTION C	CONSENT FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION (S) (signed by legal parent or legal guardian)

I HAVE BEEN INFORMED OF THE RECOMMENDATION TO PRESCRIBED MEDICATION AS A PART OF YOUTH'S TREATMENT. I HAVE BEEN INFORMED OF THE NATURE OF THE YOUTH CONDITION, THE RISK AND BENEFIT OF TREATMENT WITH MEDICATION, OF OTHER FORMS OF TREATMENT, AS WELL AS THE RISK OF NO TREATMENT. A NEW CONSENT IS REQUIRED ONCE A YEAR, WHEN A NEW MEDICATION IS STARTED AND/OR WHEN DOSAGE EXCEEDS THE MAXIMUM INDICATED IN THE DOSAGE RANGE. **FOSTER PARENTS CANNOT CONSENT TO ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS**

☐ By signing below, I give consent for _____ to receive the medications listed in section A, as recommended by his/her licensed health care provider/child psychiatrist. I understand that I can withdraw this consent to receive medications at any time during his/her treatment.

☐ By signing below, I **do not** give consent for _____ to receive the medications listed in section A, as recommended by his/her licensed health care provider/child psychiatrist. The reason consent is denied:

_____ _____

Authorized Signature Date

_____

Print Name

Relationship to Youth:_____

CONSENT FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION (signed by youth age 18 or older)

I HAVE BEEN INFORMED OF THE RECOMMENDATION TO PRECRIBED MEDICATIONS AS PART OF MY TREATMENT. I HAVE BEEN INFORMED OF THE NATURE OF MY CONDITION, THE RISK AND BENEFITS OR TREATMENT WITH THE MEDICATIONS, OF OTHER FORMS OF TREATMENT, AS WELL AS THE RISKS OF NO TREATMENT. BY SIGNING BELOW I GIVE MY CONSTENT TO RECEIVE THE MEDICATIONS LISTED IN SECTION A OF THIS DOCUMENT.

_____ _____

Signature Date

_____

Print Name

CRITERIA WARRANTING FURTHER CASE REVIEW

The following situations warrant further review of a patient's case. These criterions do not necessarily indicate that psychotropic medication treatment is inappropriate, but they do indicate a need for further review.

For youth and children that are being prescribed a psychotropic medication, any of the following prompts a need for additional review of the child's/youth's clinical status:

1. Absence of a thorough assessment of DSM 5 diagnosis in the child's medical record.
2. Four (4) or more psychotropic medication concomitantly *(side effect medications are not included in this count)*
3. The prescribed psychotropic medication is not consistent with appropriate care for the patient's diagnosed mental disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
4. Psychotropic polypharmacy for a given mental disorder is prescribed before utilizing psychotropic monotherapy.
5. The psychotropic medication dose exceeds usual recommended doses.
6. Psychotropic medications are prescribed for children less than five (5) years of age, including children receiving the following medications with an age of:

- Antidepressants: Less than four (4) years of age.
- Antipsychotics: Less than four (4) years of age.
- Psychostimulants: Less than three (3) years of age.

7. Prescribing by a Primary Care Provider (PCP) who has not documented previous specialty training for a diagnosis other than the following (unless recommended by a psychiatrist consultant).
   - Attention Deficit Hyperactive Disorder (ADHD).
   - Uncomplicated anxiety disorders.
   - Uncomplicated depression.