# PSYCHOTROPIC MEDICATION INFORMED CONSENT

| **SECTION A** | **PSYCHOTROPIC MEDICATION RECOMMENDATIONS: (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 & Credentials: | | | | | | | Telephone Number: | |
| Facility/Office Name: | | | | | Facility/Office Address: | | | |
| **Clinical Information** | | | | | | | | |
| Mental Health Diagnosis: | | | | | | | | |
| | | | | | | | | |
| Concurrent Medical Diagnosis (physical health): | | | | | | | | |

| **Current Psychotropic Medication** | | |
|---|---|---|
| MEDICATION/DOSAGE SCHEDULE | INDICATION | START DATE /PRESCRIBER |
| | | |
| | | |
| | | |
| Discontinued Psychotropic Medication(s) and Reason for Discontinuation: | | |

| **New Psychotropic Medication and Recommendations (not necessary for dosage changes within current prescribed medications)** | | |
|---|---|---|
| Name of New Medication #1: | Dosage Range: | Frequency: |
| Target Symptoms/Benefits: | Potential Side Effects: | |
| Rationale: | | |
| Tests/Procedures Required Before, During & After Medication Regimen: | Alternative Treatments: | |
| Name of New 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 New Medication #3: | 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: | Current Caregiver | 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: |
| Youth Has a Mental Health Therapist | Yes: | No: | Mental Health Therapist's Name | | | Mental Health Therapist's Phone: |

| **Section B** | **NOTIFICATION (to be completed by foster care case worker)** | | |
|---|---|---|---|
| Youth's Name: | DOB: | Legal Status: | Case#: |

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

Child is in state custody ☐Yes ☐No

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

**Comments:**

| Foster Care Case Worker's Name: | Agency: |
|---|---|
| Agency Address: | Phone Number: |

# PSYCHOTROPIC MEDICATION INFORMED CONSENT

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

I HAVE BEEN INFORMED OF THE RECOMMENDATION TO PRESCRIBE MEDICATION AS A PART OF THE YOUTH'S TREATMENT. I HAVE BEEN INFORMED OF THE NATURE OF THE YOUTH'S CONDITION, THE RISKS AND BENEFITS OF TREATMENT WITH MEDICATION, OF OTHER FORMS OF TREATMENT, AS WELL AS THE RISKS 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 prescriber. 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 prescriber. The reason consent is denied:

Authorized Signature ____________________ Date ____________________

Printed Name ____________________ Relationship to Youth ____________________

**ASSENT/CONSENT FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION (signed by youth)**

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

Signature ____________________ Date ____________________

Printed Name ____________________

**CRITERIA WARRANTING FURTHER CASE REVIEW**

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

For youth who are being prescribed a psychotropic medication, any of the following prompts a need for additional review of the youth's clinical status:

1. Absence of a thorough assessment of *DSM-5* diagnosis in the youth's medical record.
2. Four (4) or more psychotropic medications concomitantly. *(Side effect medications are not included in this count.)*
3. The prescribed psychotropic medication is not consistent with appropriate care for the youth's diagnosed mental health disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
4. Psychotropic polypharmacy for a given mental health 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:
    a. Antidepressants: Less than four (4) years of age.
    b. Antipsychotics: Less than four (4) years of age.
    c. Psychostimulants: Less than five (5) years of age.