



**PSYCHOTROPIC MEDICATION CONSENT REQUEST**

Date:		Time:	
Name of Child:			Date of Birth:

Prescriber's Specialty:	<input type="checkbox"/> Pediatrician	<input type="checkbox"/> Child Psychiatrist	<input type="checkbox"/> General Psychiatrist	<input type="checkbox"/> Other
Prescriber:			Tel # (cell):	
Return Response To: FAX #:			E-mail:	
Contact Person (if not prescriber):			Tel#:	

**CHILD CURRENT PLACEMENT:**

<input type="checkbox"/> Foster Care	<input type="checkbox"/> ISO – Foster Care	<input type="checkbox"/> Residential/Group Home	<input type="checkbox"/> Shelter	<input type="checkbox"/> Other
Name of Treatment Setting:				

**REASON FOR PSYCHOTROPIC MEDICATION REQUEST:** Check all that apply

<input type="checkbox"/> Dosage Adjustment	<input type="checkbox"/> Notification of Emergency Use	<input type="checkbox"/> Discontinue Medication
<input type="checkbox"/> New Medication	<input type="checkbox"/> Yearly Renewal	<input type="checkbox"/> Continue Current Medication *

**Medication has been explained and the youth has assented to take as prescribed**  Yes  No

<b>CURRENT PSYCHOTROPIC MEDICATIONS:</b> (Hit ENTER to add more or TAB to move on)	<b>CURRENT NON-PSYCHOTROPIC MEDICATIONS:</b> (Hit ENTER to add more or TAB to move on)

**LIST PAST MEDICATION TRIALS/ REASONS FOR DISCONTINUATION:**


**ALLERGIES:**

--

**PSYCHIATRIC DIAGNOSES:**

--

**MEDICAL DIAGNOSES:**

--

**\*\* CLINICAL REASONS/TARGET SYMPTOMS PER MEDICATION CHANGE REQUEST:**

--

**\*\*REQUESTED PSYCHOTROPIC MEDICATION CHANGE:**

Medication	Dosage/Range	Route	Schedule/Cross Taper Plan

**\*\*MONITORING STUDIES**

BP: \_\_\_\_\_ Pulse: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ BMI%: \_\_\_\_\_  
 AIMS: Normal  Abnormal  Pregnancy Test indicated? Yes  No   
 Labs: Normal:  Abnormal:   
 Drug Levels: Lithium: \_\_\_\_\_ VPA: \_\_\_\_\_ Tegretol: \_\_\_\_\_ Other: \_\_\_\_\_  
 EKG, if clinically indicated: Normal  Abnormal

Please list your proposed ways to monitor for potential side effect of the new medication ( e.g. follow up visits, labs, EKGs, vital signs AIMS exams, etc.) and their approximate frequencies (e.g. biweekly, monthly, quarterly annually)

Signature of Director or Designee	Date
Signature of Prescriber	Date



### **Instructions for Form 1653 Psychotropic Medication Consent Request**

**Purpose:**

The prescriber must form number 1653, Psychotropic Medication Consent Request and send completed form in the DCYF Foster Care Health Nurse so that DCYF administration can consent to any psychotropic medication that is being prescribed to children/youth in the legal guardianship of the Division for Children, Youth and Families.

For children and youth in DCYF guardianship, or care, custody, and control, the Foster Care Health Nurse must request the prescribing practitioner to:

- A. Complete the top of Form 1653 Psychotropic Medication Treatment Plan Consent with the prescriber's demographic information.
- B. Indicate the child/youth's current placement.
- C. Indicate the reason for this request.
  1. Indicate if the psychotropic medication identified is current, new, a change in dose, or a discontinuation.
  2. If the psychotropic medication is identified as current then the information contained will be used for review with other identified medications
  3. If the psychotropic medication is identified as new, there must be information provided regarding the purpose (i.e. to target a particular symptom, replace a medication that is not effective, or replace a medication that is having side effects).
- D. Indicate whether the youth (age 14 or older) prescribed psychotropic medication assents to the medication plan. The prescribing practitioner shall request the youth to sign Form 2287
- E. List all current psychotropic medicines the child/youth may be taking. Please indicate any other medicine the child/youth may be taking.
- F. If known, please indicate the medication that the child/youth may have used in the past and the reason for discontinuing that medication.
- G. Indicate if the child/youth has any known allergies.
- H. Indicate the psychiatric diagnosis that this child/youth has. Any diagnosis ought to be connected to the reason for this request.
- I. Indicate the symptoms that this medicine will hopefully assist with.
- J. Indicate the requested change, the Medication name, dosage, route, and schedule or cross taper plan. If the plan includes a slow increase decrease over time, please indicate the targeted ending dose as well as the increments in which the dose will be increased.
- K. Define the monitoring plan. Monitoring Plans should follow FDA recommendations to include:
  1. Height and weight monitoring,
  2. Blood pressure monitoring, and
  3. Laboratory testing as indicated on the medication matrix.
- L. Prescriber signs the form at the bottom signature line that states, signature of prescriber
- M. Signs Form 2287 Psychotropic Medication Treatment Plan Consent and Review to indicate that the medication plan is appropriate and necessary to treat the target symptoms that are identified, and that the medication plan is the least restrictive plan.
- N. Psychotropic Medication Treatment Plan Consent and Review (electronic signatures are accepted).
- O. Once completed the prescriber can forward the completed form electronically via email or by fax to the DCYF Foster Care Health Nurses for consent by DCYF administration.