



BEHAVIORAL HEALTH AND NARCOTIC MEDICATION CONSENT REQUEST

| DATE AND TIME OF REQUEST | |
|--------------------------|---|
| Date: _____ | Time: _____ <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. |

| CHILD'S INFORMATION | |
|---|--|
| Child's name: _____ | DOB: _____ |
| Child's Current Placement | |
| <input type="checkbox"/> Foster family home | <input type="checkbox"/> Relative/Kinship care |
| <input type="checkbox"/> Residential/Group home | <input type="checkbox"/> Shelter care |
| <input type="checkbox"/> ISO - foster care | |
| <input type="checkbox"/> Other: _____ | |
| Name of treatment setting: _____ | |

| PRESCRIBER INFORMATION | |
|---|---|
| Prescriber's Specialty | |
| <input type="checkbox"/> Pediatrician | <input type="checkbox"/> Child psychiatrist |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> General psychiatrist |
| Prescriber's name: _____ | Phone number: _____ |
| Return response to: | |
| Fax number: _____ | Email address: _____ |
| Contact person: (if not prescriber) _____ | Phone number: _____ |

| REASON FOR REQUEST | |
|--|--|
| <i>(Check all that apply)</i> | |
| <input type="checkbox"/> Dosage adjustment | <input type="checkbox"/> Notification of emergency use |
| <input type="checkbox"/> New medication | <input type="checkbox"/> Yearly renewal |
| <input type="checkbox"/> Discontinue medication | |
| <input type="checkbox"/> Continue current medication | |

| ASSENT (Applicable to children age 14 and older) | |
|---|--|
| The medication has been explained and the child has assented to take as prescribed <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| MEDICATION INFORMATION | |
|--|--|
| Current for behavioral health: _____ _____ _____ _____ | Current for non-behavioral health: _____ _____ _____ _____ |

| MEDICATION INFORMATION CONTINUED | |
|----------------------------------|--------------------------------|
| List past medication trials: | Reason(s) for discontinuation: |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

| ALLERGIES |
|-----------|
| |

| DIAGNOSES |
|-----------|
| AXIS I |
| AXIS II |
| AXIS III |

| CLINICAL REASONS AND TARGET SYMPTOMS |
|--------------------------------------|
| |

| THERAPEUTIC INTERVENTIONS |
|---|
| Are there therapeutic interventions in place to address the clinical reasons and symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If the answer above is yes, please answer the following 2 questions. |
| Are the current therapeutic interventions sufficient and appropriate to meet behavioral health needs? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Describe the therapeutic intervention(s) in place that target the current clinical reasons for the medication request: |
| |

| CLINICAL NOTES |
|--|
| <input type="checkbox"/> Clinical notes are attached |

| REQUESTED BEHAVIORAL HEALTH AND NARCOTIC MEDICATION CHANGE | | | |
|--|--------------|-------|---------------------------|
| Medication | Dosage/Range | Route | Schedule/Cross Taper Plan |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

| MONITORING STUDIES | | | |
|--|--|-----------------|------------------|
| Temp: _____ | BP: _____ | Pulse: _____ | Completed: _____ |
| Height: _____ | Weight: _____ | % BMI: _____ | Completed: _____ |
| Aims: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | Pregnancy test indicated? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Completed: _____ |
| Labs: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | | | Completed: _____ |
| Drug levels: | | | |
| Lithium: _____ | VPA: _____ | Tegretol: _____ | Other: _____ |
| EKG, if clinically indicated: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal | | | Completed: _____ |
| Monitoring Proposed | | | |
| 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): | | | |
| | | | |

| PROCESSING INFORMATION |
|--|
| Unable to process request at this time due to: |
| |

| INFORMED CONSENT APPROVAL | |
|---------------------------------------|-------------|
| _____ | _____ |
| <i>Prescriber's signature</i> | <i>Date</i> |
| _____ | _____ |
| <i>Director or designee signature</i> | <i>Date</i> |