Child Name:_____ Date:_____

CONSENT FOR PSYCHOTROPIC MEDICATION

In accordance with foster care policy, only the LDSS that holds custody of the child can provide consent for psychotropic medications. Prior to the youth being placed on a new psychotropic medication, the youth should receive: a) a pediatric medical examination to ensure symptoms are not indicative of a medical problem, except in the case of an emergency (in an emergency, a physical examination should be conducted as soon as possible) b) a comprehensive child and adolescent behavioral health evaluation by a licensed mental health professional to identify psychosocial interventions.

ASSESSMENT & EXAMINATION			
Primary Psychiatric Diagnoses (DSM-5):			
Please list any other medical diagnoses and non-psychotropic medication (including allergies):			
CURRENT PSYCHOTROPIC MEDICATIONS			
Medication	**Dosage & Frequency**	**Target Symptoms**	**Start Date:**
#1			
Prescriber:	**Potential Side effects:**		
#2			
Prescriber:	**Potential Side effects:**		
#3			
Prescriber:	**Potential Side effects:**		
PROPOSED PSYCHOTROPIC MEDICATIONS			
Medication	**Dosage & Frequency**	**Target Symptoms**	**Start Date:**
#1			
Prescriber:	**Potential Side effects:**		
#2			
Prescriber:	**Potential Side effects:**		
Prescriber:	**Potential Side effects:**		
Discontinued psychotropic medication:			
TREATMENT & INTERVENTIONS			
Is there a medication treatment plan?	☐ Yes	☐ No	

Does the medication treatment plan include the following? (Check all that apply)

☐Dosage (how much) ☐Medication purpose ☐Medication review(s) ☐Medication discontinuation plan (if applicable)

Describe interventions/therapies being used:

INFORMED CONSENT

Prior to administration of psychotropic medication, was the youth involved in the decision-making process, including receiving the *Making Healthy Choices* Guide and given information regarding the proposed medication and side effects and assent provided as appropriate for age and development?	☐ Yes	☐ No	**Input from youth:**

Prior to the approval of psychotropic medication, were the following individuals informed?

☐ Mother ☐ Father ☐ Caregiver ☐ Guardian

☐ Family Services Specialist Worker ☐ TFC Case Manager

Input from individuals:

I have received information describing:

- **Youth's condition to be treated;**
- **The beneficial effects expected from the medication on that condition;**
- **Potential consequences of not consenting to the medication;**
- **Potential side effects and risks associated with the medication;**
- **And other forms of treatment and the reasons for the proposed treatment.**

This consent is given voluntarily and without due influence.

I understand that I have the right to choose not to consent to this medication. I understand that I have the right to withdraw consent for this treatment at any time.

☐ By signing below, I give consent for this youth to receive the medications listed above, as recommended by their licensed health care provider/child psychiatrist.

☐ By signing below, I **do not** consent for this youth to receive the medications listed above, as recommended by their licensed health care provider/child psychiatrist. The reason consent is denied and next steps:_ _____

_____ _____

Signature of Psychotropic Medication Consenter (PMC) Date

_____ _____

Printed Name Relationship to Youth

Situations in which a psychiatric consult or second opinion may be warranted:

☐ Absence of thorough assessment (medical & mental health) or DSM diagnosis in child's medical and/or foster care record

☐ Taking three or more medications at the same time

☐ Prescribing more than one medication for a symptom before trying a single medication

☐ Medication dose exceeds usual recommended dose

☐ Prescribing medication that have adverse side effects*

☐ Prescribing medication that is not FDA approved for children

☐ Child/youth is less than six years old

☐ Prescriptions by primary care provider with no documented specialty training for diagnosis other than attention deficit hyperactive disorder (ADHD) or uncomplicated anxiety disorder

☐ Taking two or more medications for the same purpose

☐ Others:_____

_____

***Medications with adverse side effects may include those with the potential to induce or increase the child/youth's risk for: suicidal thoughts, raised cholesterol level, weight gain, diabetes, tardive dyskinesia, sun sensitivity/dehydration, etc*

PMC Review of Consent:

_____ _____ _____ _____

PMC Signature Date PMC Signature Date

_____ _____ _____ _____

PMC Signature Date PMC Signature Date

Medications (continued)			
Medication	**Dosage & Frequency**	**Target Symptoms**	**Start Date:**
Prescriber:	**Potential Side effects:**		
Prescriber:	**Potential Side effects:**		
Prescriber:	**Potential Side effects:**		
Prescriber:	**Potential Side effects:**		
Prescriber:	**Potential Side effects:**		
Prescriber:	**Potential Side effects:**		