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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICESCHILDREN’S DIVISION**Informed Consent For Psychotropic Medication** |
| PART A: *To be completed by the case manager or authorized consenter – prior to appointment with prescriber* |
| Name of child      | DCN       | Child's date of birth (month, day, year)      |
| Name of prescriber      |  Date of office visit       |
| Prescriber office name and address       | Prescriber contact number(   )      |
| Purpose of visit: [ ]  New Start [ ]  Monitoring Appointment [ ]  Yearly Consultation | Current illnesses       |
| Other |       |
|  |
| List diagnosis and date: (*month, day, year*)       | Known allergies       |
| Psychiatric history and treatments        |
| Was the youth given psychotropic medications for an emergency since the last informed consent decision or medication change? [ ]  Yes [ ]  No  |
|  If yes, please explain the situation below: Date emergency medication was administered:            |
| Is the youth currently prescribed other non-psychotropic medications? [ ]  Yes [ ]  No If yes, list:        |
| List any side effects/adverse reactions to previously prescribed psychotropic and non-psychotropic medications:       |
| Did the youth have a recommendation from a prescriber for concurrent non- pharmacological treatment? [ ]  Yes [ ]  No If yes, did the youth receive the concurrent non- pharmacological treatment at the recommended frequency [ ]  Yes [ ]  No and duration [ ]  Yes [ ]  No |
| Part B: *To be completed by case manager or authorized consenter in conjunction with prescriber* |

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| **List of Psychotropic Medications** |
| **Medication Name** | **Dosage** | **Frequency**  | **Duration** | **Side Effects** | **Reason for Medication** | **New Medication** | **No Changes****Made** |
|       |       |       |       |       |       | [ ]  Yes [ ]  No | [ ]  |
|       |       |       |       |       |       | [ ]  Yes [ ]  No | [ ]  |
|       |       |       |       |       |       | [ ]  Yes [ ]  No | [ ]  |
|       |       |       |       |       |       | [ ]  Yes [ ]  No | [ ]  |
|       |       |       |       |       |       | [ ]  Yes [ ]  No | [ ]  |
| The benefits of usage and non-usage were discussed. [ ]  Yes [ ]  NoExplain:       |
| Is there a dosage outside of the Excessive Dosage guidelines? [ ]  Yes [ ]  No |
| *If yes, explain. Also comment on any off label usage:*       |
| Potential side effects and/or adverse reactions for each medication listed were discussed with the prescriber. [ ]  Yes [ ]  No |
| Alternate treatment options were discussed (use of/success of, and progress of treatment): [ ]  Yes [ ]  No (check all that apply) |
| [ ]  Individual Therapy [ ]  Family Therapy [ ]  Group Therapy [ ]  Healthy Eating [ ]  Weight/Exercise [ ]  Sleep Hygiene [ ]  Light Therapy |
| [ ]  Other |       |  |
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| Did the prescriber recommend any metabolic screenings (e.g., Comprehensive Metabolic Panel (CMP), Complete Blood Count (CBC))? [ ]  Yes [ ]  No If yes, were the screenings completed? [ ]  Yes [ ]  No[ ]  Lipids [ ]  EKG [ ]  TSH/T4 [ ]  CBC [ ]  CMP [ ]  A1C [ ]  Medication levels       other:       |
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| Recommended frequency follow-up date per Prescriber:       |

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| Potential interactions with other non-psychotropic medications the youth takes were discussed. [ ]  Yes [ ]  NoExplain:       |

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| **Parental Notification:**  |
| **Legal parent(s) were contacted regarding a recommendation for psychotropic medication(s):** [ ]   **Yes** [ ]   **No If no, why?**      **Not required to notify due to:**       |

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| Parent 1 Name:       | Date of Contact/Attempt #1      Date of Contact/Attempt #2       | Contact Method #1Contact Method #2 | [ ]  Call [ ]  Electronic [ ]  In Person [ ]  Letter[ ]  Call [ ]  Electronic [ ]  In Person [ ]  Letter |
| Parent 2 Name:       | Date of Contact/Attempt #1      Date of Contact/Attempt #2       | Contact Method #1Contact Method #2 | [ ]  Call [ ]  Electronic [ ]  In Person [ ]  Letter[ ]  Call [ ]  Electronic [ ]  In Person [ ]  Letter |
| **During contact with each parent, the following topics were discussed: (Please check each topic discussed)** |
| **Parent 1** | **Parent 2** |
| [ ]  Diagnosis [ ]  Medication, dosage and purpose [ ]  Possible side effects [ ]  Prognosis without intervention [ ]  Prescriber contact information [ ]  Availability of alternatives [ ]  Required follow up or monitoring | [ ]  Diagnosis [ ]  Medication, dosage and purpose [ ]  Possible side effects [ ]  Prognosis without intervention [ ]  Prescriber contact information [ ]  Availability of alternatives [ ]  Required follow up or monitoring |
| Parent 1 in agreement with recommendation: [ ]  Yes [ ]  No | Parent 2 in agreement with recommendation: [ ]  Yes [ ]  No |

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|  **Youth Assent (to be completed by youth age 12 -17 years of age):** |
|  **My rights have been explained to me (the prescriber talked to me about the above medications, and I have had the chance to ask questions):**[ ]  Yes [ ]  No  |
|  I received a copy of the Learn Your Rights (CD-281) flyer [ ]  Yes [ ]  No Date when the flyer was provided:       |
|  A copy of Learn Your Rights (CD-281) was provided to GAL/Attorney [ ]  Yes [ ]  No Date when the flyer was provided:       |
| **Comments:**      |
|  |  |  |       | Case Manager/Alternative Consenter participated in person or by phone with youth [ ]  Yes [ ]  No |
|  | Signature of youth |  | Date |  |
| **Center for Excellence Referral:** |
|  If required or necessary, was a secondary or mandatory referral sent to the Center for Excellence. [ ]  **Yes** [ ]  **No** [ ]  **N/A**  Type of referral: [ ]  Secondary [ ]  Mandatory **Date of Referral:**       |
| **Authorization for administration of psychotropic medications:** |
|  Has there been an informed consent review within the last three months with a designated supervisor? [ ]  Yes [ ]  No Date last review completed:        |
|  By signing below, [ ]  I give consent [ ]  **I do not** give consent for        To receive the new medication(s) listed in part B List of Psychotropic Medications as recommended by his/her healthcare provider. **(If authorization is denied, reason must be provided below.)** |
| **Reason authorization denied:**      |
|  |  |  |       |  |       |
|  | Signature of Children’s Division Case Manager/designee or authorized consenter |  | Date |  | Phone Number (accessible in emergencies) |
|  |       |  |
|  | Print Name |  |