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|  | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’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  No  Explain: | | | | | | | | | |
| 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 |  | | | |  | | | | |
|  |  | | | |  | | | | |
| 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  No  Explain: |

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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 #1  Contact 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 #1  Contact 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 | | |  | | | |