**Sample Psychotropic Medication Informed Consent Form**

Member Last Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member First Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member MI:\_\_\_\_\_\_\_\_

Member ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENTAL/GUARDIAN CONSENT STATEMENT**

**MY UNDERSTANDING IS THE FOLLOWING:**

* I am the Child’s Medical Consenter.
* Typically, medication is prescribed as part of a treatment plan that includes counseling services.
* I was given information about what to expect without treatment, with counseling only, with medication(s) only, and with both counseling and medication(s).
* Medication(s) should not be discontinued abruptly and the plan to taper and discontinue medication(s) should be overseen by the prescriber.
* I can refuse the use of this or any other medication(s) at any time.
* Medication(s) may sometimes cause behavior or health problems; occasionally they can be permanent.
* I was given an information sheet about the recommended medication(s). The sheet notes:
  + The Food and Drug Administration approval for using the medication in children
  + Any safety concerns
  + How to safely stop taking the medication
  + What to do about missing a dose
  + How to keep track of the effects of the medication.
* The effects and risks of medication(s) may change over time. I understand that my child will need regular visits with the prescriber to make sure it is safe to keep using the medication(s).
* I would like to learn more about available Care Management/Coordination services. **YES NO**

**PRESCRIBER SECTION:**

* **TARGETED SYMPTOMS** (signs and symptoms identified by the prescriber for treatment with psychotropic medication(s)):

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* **A comprehensive mental health or developmental/behavioral evaluation was performed (circle one):**

> 12 months ago In the past 12 months Current referral No evaluation planned

* **Patient and/or family counseling or behavioral intervention (circle one)?**

Past Current Referred No

If No, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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* Prescriber additional comments: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATION SECTION:**

**PSYCHOTROPIC MEDICATION(S) RECOMMENDATION, DOSE, DOSING INSTRUCTIONS**:

Psychotropic medication(s) previously used and outcome: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Other psychotropic medication(s) continued or started: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I **have explained to the parent/guardian/medical consenter of the patient the risks and benefits of the medication(s)**

**via PHONE\_\_\_\_\_\_\_ or FACE-to-FACE \_\_\_\_\_\_\_**

PRESCRIBER SIGNATURE DATE TIME

PRINT NAME

## As the parent/guardian/medical consenter of the patient named, I understand the risks and benefits of the medication(s) as they have been explained to me and I consent to the use of the recommended medication(s).

PARENT/GUARDIAN/MEDICAL CONSENTER SIGNATURE DATE TIME

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME DATE TIME