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)):

_____

_____

_____

- **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: _____

  _____

- Prescriber additional comments: _____
  _____

MEDICATION SECTION:

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

_____
_____

Psychotropic medication(s) previously used and outcome:

_____
_____

Other psychotropic medication(s) continued or started: _____
_____
_____

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