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:
  o The Food and Drug Administration approval for using the medication in children
  o Any safety concerns
  o How to safely stop taking the medication
  o What to do about missing a dose
  o 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)?

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<thead>
<tr>
<th>Past</th>
<th>Current</th>
<th>Referred</th>
<th>No</th>
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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 CONSENDER SIGNATURE  DATE  TIME

PRINT NAME  DATE  TIME