PSYCHOTROPIC MEDICATION INFORMED CONSENT

Michigan Department of Human Services

Date of appointment:

Section A – Psychotropic medication recommendation: (to be completed by licensed medical professional)

Identifying Information: Please Print

Child name:	Date of birth:
Sex: ☐ Male ☐ Female	Height: / Weight:
Prescribing health care provider:	Telephone number: ( )
Office/Facility name:	Office/Facility address:

Clinical Information:

Concurrent medical diagnoses:

All mental health diagnoses:

All current psychotropic medications:

Medication/dosage/administration schedule	Medication/dosage/administration schedule	Medication/dosage/administration schedule

Discontinued psychotropic medication:

New medications and recommendations: (not necessary for dosage changes within current prescribed dosage range)

Name of medication #1:	Dosage Range –	Frequency of administration
Target symptoms/benefits:	Potential Side effects:	

Rationale (Required only if prescribed medication falls within *Criteria Triggering Further Review (see bottom of pg. 2)*[1]

Tests/procedures required before/during medication regimen:	Alternative treatments:

Review of Above Information:

With child: ☐ Yes ☐ No

With foster parent/current foster care placement: ☐ Yes ☐ No Foster parent(s) name:

If child is a temporary court ward was the information above reviewed with Legal Parent(s)/Guardian:

☐ Yes ☐ No

If yes, method of review:

☐ In-person ☐ Telephone

Name of medication #2 (use another DHS-1643 for 3 or more medications):	Dosage Range –	Frequency of administration
Target symptoms/benefits:	Potential Side effects:	

Rationale (Required only if prescribed medication falls within *Criteria Triggering Further Review (see bottom of pg. 2)*[1]

Tests/procedures required before/during medication regimen:	Alternative treatments:

Review of Above Information:

With child: ☐ Yes ☐ No

With foster parent/current foster care placement: ☐ Yes ☐ No Foster parent(s) name:

If child is a temporary court ward was the information above reviewed with Legal Parent(s)/Guardian:

☐ Yes ☐ No

If yes, method of review:

☐ In-person ☐ Telephone

Signature

(Prescribing licensed medical professional) (Date)

DHS Psychotropic Medication Informed Consent

Section B – Notification (to be completed by caseworker):

Child Name:	DOB:	Legal Status:

☐ Legal parent(s) were notified of psychotropic medications ☐ Yes ☐ No

☐ Child is a state ward.

For Temporary Court Wards medication cannot be administered until signed consent is received from parent/legal guardian or the court.

Comments

Caseworker Name:	Agency/DHS Local Office
Address:	Phone Number: ( )

Section C – Consent for administration of psychotropic medications (signed by legal parent or legal guardian):

I have been informed of the recommendation to prescribe medications as part of my treatment. I have been informed of the nature of my condition, the risks and benefits or treatment with the medications, of other forms of treatment, as well as the risks of no treatment.

Foster Parents cannot consent to administration of psychotropic medications

☐ By signing below, I give consent for _____ to receive the medications listed in section A, as recommended by his/her licensed health care provider. I understand that I can withdraw this consent for my child to receive medications at any time during his/her treatment.

☐ By signing below, I do not give consent for _____ to receive the medications listed in section A, as recommended by his/her licensed health care provider. Reason consent denied:[2]

_____ _____

Authorized Signature Date

Relationship to Child:

_____

Print Name:

Section C – Consent for administration of psychotropic medications (signed by youth age 18 or older):

I have been informed of the recommendation to prescribe medications as part of my treatment. I have been informed of the nature of my condition, the risks and benefits or treatment with the medications, of other forms of treatment, as well as the risks of no treatment.

_____ _____

Signature Date

A new signed consent is required once a year, when a new medication is started and/or when the dosage exceeds the maximum indicated in the dosage range.

Criteria Triggering Further Review

☐ Prescribed four or more concomitant psychotropic medications

☐ Prescribed two or more concomitant anti-depressants.

☐ Prescribed two or more concomitant anti-psychotics.

☐ Prescribed two or more concomitant stimulant medications.

☐ Prescribed two or more concomitant mood stabilizer medications.

☐ Prescribed psychotropic medications in doses above recommended doses

☐ Prescribed psychotropic medication and child is five years or younger.

[1] **To the physician:** In compliance with the MDHS Guidelines for the Use of Psychotropic Medication for Children in State Custody, the above medication combinations should be avoided. These parameters do not necessarily indicate treatment is inappropriate, but for DHS purposes further review is needed. Check the appropriate box if any apply. An explanation must be provided within the rationale section (under the Medications on pg.1), and you may be contacted for follow up.

[1] **To the caseworker:** If the Rationale field in section A is completed and one or more of the check boxes are checked, a copy of the completed Psychotropic Medication Consent Form must be faxed to the DHS Health, Education & Youth Unit at 517-335-7789.

[2] If consent is denied and all other parties agree medication is needed, a court order is necessary for medication to be administered.