Reset

South Carolina Department of Social Services

INFORMED CONSENT AND NOTIFICATION REGARDING PSYCHOTROPIC MEDICATION

Directions: Complete Part A and B and fax form to SCDSS at 888-816-5853. Parts C and D will be completed by DSS and copies will be returned to the prescribing physician provider. Complete and send this form when Child enters PRTF to establish baseline medications the child came on, starting new medications, increasing or decreasing dose beyond previously approved dose limits, discontinuing medications and use of Emergent medications. **Consent must be obtained before administering new medication and increasing dose beyond previously approved dose limit, except in emergencies.**

PART A – To be completed by the prescribing physician

Name of Child: ____________ Child's Date of Birth: (MM/DD/YYYY) ____________ Child's Sex: ❑ Male ❑ Female

Child's Height (in feet/inches) and date measured: ____________ Child's Weight (in pounds) and date measured: ____________

Prescriber Name: ____________ Prescriber Contact No.: ____________ Prescriber Fax No.: ____________

Prescriber Specialty: ❑ Pediatrician ❑ Psychiatrist ❑ C&A Psychiatrist ❑ Family Medicine ❑ Other: ____________

Psychiatric Diagnosis: (Also provide numerical codes. Circle the primary diagnosis.) ____________

Any Medical Diagnosis: ____________

Is this notification for medication administered without consent due to emergency or due to being existing medication(s) at time of admission to a PRTF?

❑ Yes, existing medication(s) at time of admission to a PRTF

❑ Yes, emergency usage. Explain: ____________

All Psychiatric Medications (Existing and new ones being requested)	Dose (Starting and maximum dose)	Route	Freq.	Target Symptoms and Rationale for Change in Medications	Recommended Action: Please
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose
					❑ Start ❑ Stop ❑ No Change ❑ Increase Dose ❑ Decrease Dose

Psychotropic medications given on a prn basis are not preferred. If short term use for PRN is requested, please provide rationale and plan to discontinue: **(PRN IS NOT TO BE USED AS CHEMICAL RESTRAINT.)**

List all other medications/OTC this child is currently prescribed: (Medication name, dose, and frequency. Use additional sheet if needed)

Explain how the child will be monitored for safety and efficacy while on this medication. Note most recent AIMS score/date if child is on antipsychotics:

Labs for Mood stabilizers/Lithium or other Psychotropic Medications: (And date measured)

For ADHD medications please indicate:

Child's Blood Pressure: (And date measured) ____________ Child's Pulse: (And date measured) ____________

For antipsychotics please indicate:

Fasting Blood Glucose: (And date measured) ____________ Fasting Lipid Profile (Total/LDL/HDL/TG): (And date measured) ____________

Please note what additional treatment will be used (e.g., individual counseling, etc.), and the administering provider. Please include any additional clinical information that supports this treatment recommendation or change in medication/s. Include pertinent past medication trials:

The potential risks and benefits of each medication have been explained to the child including what would happen if the child does not take each medication as prescribed, and other, non-medication options for treating target symptoms. ❑ Yes ❑ No

Does child object? ❑ Yes ❑ No

By signing below I agree the information above is accurate to the best of my knowledge. I understand submission of this form represents the beginning of the consent process with DSS.

Signature of Physician: ____________ Physician NPI: ____________ Date: (MM/DD/YYYY) ____________

PART B – To be completed ONLY if child is 16 years old or older and is legally competent

My signature below represents my informed decision about the medication recommended on this form. My doctor explained my diagnosis to me. My doctor told me what would happen if I took the medication (both good things and possible side effects), what would happen if I did not take the medication, and other options (besides medication) to treat my symptoms.

❑ I consent to the medication(s) ❑ I do **NOT** consent to the medication(s)

Signature of Child: _____ Date (MM/DD/YYYY) and Time: _____

Printed Name of Child: _____

PART C – To be completed by DSS

Determination: ❑ Approved ❑ Denied ❑ Doc to Doc requested ❑ Modified and details of Modifications as below:

_____

_____

Name of Reviewing Psychiatrist: _____ Date (MM/DD/YYYY) and Time Reviewed: _____

Signature of DSS Representative: _____ Date (MM/DD/YYYY) and Time: _____

Printed Name of DSS Representative: _____

Contact Number of DSS Representative for any concerns regarding Denial or modification: _____

Contact Number of DSS Psychiatrist if Doc to Doc requested: _____

PART D – Internal record keeping

Check as each task is complete:

❑ Copy of completed form sent to prescriber
❑ Copy of completed form sent to case manager** ❑ N/A
❑ Copy of completed form sent to child's placement
❑ Copy of completed form sent to service coordinator** ❑ N/A
❑ Copy of completed form sent to data entry
❑ Data entry complete

Child's County of Origin: Select County ...

Child's Case Manager or County Contact Person: _____

** **ATTENTION CASE MANAGERS AND SERVICE COORDINATORS:** Please place a copy of this completed form in the child's paper chart.

Please review:

- **Use of PRN is time limited and not used in place of other psychosocial interventions.**
- **There is weaning from one drug that is ineffective while beginning another.**
- **If dose is outside standard range, there is sound rationale for that.**
- **For antipsychotic use please review how it relates to patient's diagnosis and or symptoms targeted.**
- **Rationale for use of multiple medications and efforts been made to decrease any previous unnecessary medications to avoid unwanted interactions.**
- **Are these medications available on Medicaid Fee for Service Formulary or there is prior approval from Medicaid.**
- **This medication regimen can be carried out in community.**