Appendix I

PSYCHOTROPIC MEDICATION INFORMED CONSENT

MARYLAND DEPARTMENT OF HUMAN RESOURCES
SOCIAL SERVICES ADMINISTRATION

SECTION A	PSYCHOTROPIC MEDICATION RECOMMENDATION: (to be completed by licensed medical professional)							
Name:					Date of Visit:			
Gender:	Female:		Male:		DOB:		Age:	
Height:		Weight:		Blood Pressure:		Pulse:		
Prescribing Provider's Name:						Telephone Number:		
Facility/Office Name:				Facility/Office Address:				

Diagnosis (Current DSM Diagnoses) ***Please Check All That Apply***

☐ Autism ☐ MR/DD/PDD ☐ Traumatic Brain Injury ☐ Terminal Illness *(please specify)*_____ ☐ Tourettes Syndrome ☐ ADHD ☐ Conduct Disorder	☐ Oppositional Defiant Disorder ☐ Bipolar Disorder ☐ Major Depressive Disorder ☐ Mood Disorder (NOS) ☐ Post Traumatic Stress Disorder ☐ Schizophrenia ☐ Psychotic Disorder NOS	☐ Generalized Anxiety Disorder ☐ Social Anxiety Disorder ☐ Other Anxiety Disorder ☐ Obsessive Compulsive Disorder ☐ Panic Disorder ☐ Other ***(please specify):***

Concurrent Medical Diagnosis ***(check all that apply)***

☐ Anemia ☐ Arthritis ☐ Asthma/Wheezing ☐ Bedwetting ☐ Chronic Fatigue ☐ Chronic Pain	☐ Constipation ☐ Cystic Fibrosis ☐ Diabetes (Type I) ☐ Diabetes (Type II) ☐ Eczema ☐ Epilepsy/Seizures	☐ Headaches/Migraines ☐ Hearing Problems ☐ Heart Problems ☐ High Blood Pressure ☐ Kidney Disease ☐ Lead Poisoning	☐ Sickle Cell ☐ Skin Disorder ☐ Thyroid Disorder ☐ HIV (AIDS) ☐ Other***(please specify):***

Current Psychotropic Medications

Target Symptoms ***(Check all target symptoms for which current medications are being prescribed)***

Current Medication/Dosage Administration Schedule	Current Medication/Dosage Administration Schedule	Current Medication/Dosage Administration Schedule

New Psychotropic Medications and Recommendations (not necessary for dosage changes within current prescribed medications)

Target Symptoms ***(Check all target symptoms for which new medications are being prescribed)***

☐ Irritability ☐ Aggression ☐ Impulsivity ☐ Sleep Disturbance	☐ Hallucinations ☐ Delusion ☐ Depression ☐ Hyperactivity	☐ Anxiety ☐ Manic Episode ☐ Self-Injurious Behavior ☐ Mood Instability ☐ Other ***(please specify):***

Name of Medication #1:	Dosage Range:	Frequency:
Potential Side Effects:		
Tests/Procedures required before, during & after medication regimen:	Alternative Treatments:	
Name of Medication #2:	Dosage Range:	Frequency:
Potential Side Effects:		
Tests/Procedures required before, during & after medication regimen:	Alternative Treatments:	
Name of Medication #3: **(use another DHR/SSA-631-G form for 3 or more medications)**	Dosage Range:	Frequency:
Potential Side Effects:		

Reviewed All Above Information

With Youth	Yes:	No:	With parent , foster parent or current foster placement	Yes:	No:	Parent's, Foster Parent's or Placement Name:
Foster Care Case Worker	Yes:	No:	Foster Care Case Worker's Name:			Foster Care Case Worker's Phone Number:
Child Psychiatrist (**Complete if prescribing clinician is not a child psychiatrist)**			Yes:	No:	Child Psychiatrist's Name:	Child Psychiatrist's Phone Number

SECTION B	NOTIFICATION (to be completed by youth's foster care case worker before youth sees doctor or licensed professional)		
Child Name:	DOB:	Legal Status:	MDCHESSIE #::

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

Child is in state custody ☐ Yes ☐ No

For children that are in temporary custody, medications cannot be administered until signed consent is received from parent/legal guardian or the court.

Comments:

Foster Care Case Worker's Name:	Jurisdiction:
LDSS Address:	Phone Number:

SECTION C	CONSENT FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION (S) (signed by legal parent ,legal guardian, or LDSS Director or Assistant Director)

I HAVE BEEN INFORMED OF THE RECOMMENDATION TO PRESCRIBED MEDICATION AS A PART OF YOUTH'S TREATMENT. I HAVE BEEN INFORMED OF THE NATURE OF THE YOUTH CONDITION, THE RISK AND BENEFIT OF TREATMENT WITH MEDICATION, OF OTHER FORMS OF TREATMENT, AS WELL AS THE RISK OF NO TREATMENT. A NEW CONSENT IS REQUIRED ONCE A YEAR, WHEN A NEW MEDICATION IS STARTED AND/OR WHEN DOSAGE EXCEEDS THE MAXIMUM INDICATED IN THE DOSAGE RANGE. **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/child psychiatrist. I understand that I can withdraw this consent 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/child psychiatrist. The reason consent is denied:

_____ _____

Authorized Signature Date

_____

Print Name

Relationship to Youth:_____

SECTION D	ASSENT FOR ASMINISTRATION OF PSYCHOTROPIC MEDICATION(to be completed by youth ages 16 and older)

I HAVE BEEN INFORMED OF THE RECOMMENDATION TO PRECRIBED MEDICATIONS AS PART OF MY TREATMENT. I HAVE BEEN INFORMED OF THE NATURE OF MY CONDITION, THE RISK AND BENEFITS OR TREATMENT WITH THE MEDICATIONS, OF OTHER FORMS OF TREATMENT, AS WELL AS THE RISKS OF NO TREATMENT. BY SIGNING BELOW I GIVE MY CONSENT TO RECEIVE THE MEDICATIONS LISTED IN SECTION A OF THIS DOCUMENT.

_____ _____

Signature Date

_____

Print Name

☐ I do not consent to receive the medications listed in section A of this document

Reason for youth not consenting to receive medications recommended in section A :