IOWA Health and Human Services

Psychotropic Medication Informed Consent

Section A: Psychotropic Medication Recommendations

(To be completed by licensed medical professional)

Name:	
Date of Visit:	DOB:
Sex: Male Female	Age:
Weight:	Height:
Blood Pressure:	Pulse:
Prescribing Provider's Name & Credentials:	Facility/Office Address:

Clinical Information
Mental Health Diagnosis:
Concurrent Medical Diagnoses (physical health):

Medication(s) to be Continued at Current Dose		
Medication/Dosage Schedule	**Diagnosis**	**Start Date/Prescriber**
Reason for medication change and/or discontinuation		

New or Changed Psychotropic Medication and Recommendations	
NEW MEDICATION #1	
Dosage Range:	Frequency:
Target Diagnosis	Potential Side Effects:
Rationale (benefits):	
Tests/Procedures Required:	Previous Treatments/Therapies

NEW MEDICATION #2	
Dosage Range:	Frequency:
Target Diagnosis	Potential Side Effects:
Rationale (benefits):	
Tests/Procedures Required:	Previous Treatments/Therapies

NEW MEDICATION #3	
Dosage Range:	Frequency:
Target Diagnosis	Potential Side Effects:
Rationale (benefits):	
Tests/Procedures Required:	Previous Treatments/Therapies

Reviewed All Above Information		
With Youth: ☐ Yes ☐ No	With Parent/Guardian: ☐ Yes ☐ No	Parent/Guardian Name:
Kin Caregiver/Foster Parent: ☐ Yes ☐ No	Kin Caregiver/Foster Parent Name:	Kin Caregiver/Foster Parent Phone:

Section B: Notification

(To be completed by CPW/SWCM)

Youth's Name:	DOB:	Legal Status:	Case #:
Legal Parent(s) notified of psychotropic medications: ☐ Yes ☐ No If no, what attempts were made to notify them?			
Child is in state custody: ☐ Yes ☐ No Comments:			
Social Work Case Manager's Name:	Service Area:		
Agency Address:	Phone Number:		

Section C: Consent for Administration of Psychotropic Medication(s)

Signed by legal parent or legal guardian

I have been informed of the recommendation to prescribe medication as a part of the youth's treatment. I have been informed of the nature of the youth's condition, the risks and benefits of treatment with medication, of other forms of treatment, as well as the risks 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.

☐ By signing below, **I give consent** for _____to receive the medications listed in Section A, as recommended by their licensed health care provider. I understand that I can withdraw this consent to receive medications at any time during their treatment.

☐ By signing below, **I do not give consent** for _____to receive the medications listed in Section A, as recommended by their licensed health care provider. The reason consent is denied:

_____ _____
Authorized Signature Date

_____ _____
Printed Name Relationship to Youth

Assent/Consent for Administration of Psychotropic Medication

Signed by Youth

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 of treatment with the medications, of other forms of treatment, as well as the risks of no treatment. By signing below, I give my assent/consent to receive the medications listed in section a of this document.

_____ _____
Authorized Signature Date

_____
Printed Name

Signed by Substitute Decision Maker

☐ By signing below, **I give consent** for _____to receive the medications listed in Section A, as recommended by their licensed health care provider. Authority was granted by the juvenile court on _____. A copy of the court order is attached.

_____ _____
Authorized Signature Date

_____
Printed Name

Criteria Warranting Further Case Review

The following situations warrant further review of a youth's case. These criteria do not necessarily indicate that psychotropic medication treatment is inappropriate, but they do indicate a need for further review. For youth who are being prescribed a psychotropic medication, any of the following prompts a need for additional review of the youth's clinical status:

1. Absence of a thorough assessment of DSM-5 diagnosis in the youth's medical record.
2. Four (4) or more psychotropic medications prescribed at the same time.
3. Multiple medications are prescribed for the treatment of a single mental health disorder before trying a single medication.
4. The psychotropic medication dose exceeds usual recommended doses.
5. Psychotropic medications are prescribed for children less than six (6) years of age, including children receiving the following medications with an age of:
    a. Antidepressants: Less than five (5) years of age.
    b. Antipsychotics: Less than five (5) years of age.
    c. Psychostimulants: Less than six (6) years of age.
6. The prescribed psychotropic medication raises concerns that the provider hasn't addressed and requires further review.