STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

SECTION A PSYCHOTROPIC MEDICATION RECOMMENDATIONS

(to be completed by licensed medical professional)

Name:		Date of Visit:	DOB:
Gender: ◯ Male ◯ Female ◯ Self-identify: _____	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
Discontinued Psychotropic Medication(s) and Reason for Discontinuation:		

NEW OR CHANGED PSYCHOTROPIC MEDICATION AND RECOMMENDATIONS

NEW MEDICATION #1	Dosage Range:	Frequency:
Target Symptoms/Benefits:	Potential Side Effects:	
Rationale:		
Tests/Procedures Required:	Alternative Treatments:	
NEW MEDICATION #2	Dosage Range:	Frequency:
Target Symptoms/Benefits:	Potential Side Effects:	
Rationale:		
Tests/Procedures Required:	Alternative Treatments:	

(continued)

NEW PSYCHOTROPIC MEDICATION AND RECOMMENDATIONS		
NEW MEDICATION #3	Dosage Range:	Frequency:
Target Symptoms/Benefits:	Potential Side Effects:	
Rationale:		
Tests/Procedures Required:	Alternative Treatments:	

REVIEWED ALL ABOVE INFORMATION		
With Youth: YES NO	With Parent/Guardian: YES NO	Parent/Guardian's Name:
Kin Caregiver/Foster Parent: YES NO	Kin Caregiver/Foster Parent's Name:	Kin Caregiver/Foster Parent's 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.

(Date)

_____ _____

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 concomitantly. *(Side effect medications are not included in this count.)*
3. The prescribed psychotropic medication is not consistent with appropriate care for the youth's diagnosed mental health disorder or with documented target symptoms usually associated with a therapeutic response to the medication prescribed.
4. Psychotropic polypharmacy for a given mental health disorder is prescribed before utilizing psychotropic monotherapy.
5. The psychotropic medication dose exceeds usual recommended doses.
6. Psychotropic medications are prescribed for children less than five (5) years of age, including children receiving the following medications with an age of:
    a. Antidepressants: Less than four (4) years of age.
    b. Antipsychotics: Less than four (4) years of age.
    c. Psychostimulants: Less than five (5) years of age.