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INFORMED CONSENT FOR PSYCHOTHERAPEUTIC MEDICATION

[Children 0 to < 13 Years Old - *F.S. 394.492(3)*]

F.S. 409.912(51) *The Agency may not pay for a psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian.* ***The physician shall document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.***

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, AR, PA)

Prescriber Phone Number -

Prescriber Fax Number -

Psychotherapeutic Medication *[antipsychotics, antidepressants, anti-anxiety, mood stabilizers (anticonvulsants and ADHD medications not included)]*	**Dose Range**

Diagnosis:	Target Symptoms:	Expected Outcome:
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I have discussed possible **other treatments** with the parent/guardian providing informed consent.

☐ I have discussed the **reason for treatment**, the **expected outcome**, the approximate **length of treatment**, and how the treatment will be **monitored** with the parent/guardian providing consent. I have also discussed the benefits and risks of this psychotherapeutic medication including the possible **side effects**, the potential **medication interactions**, **contraindications** and the potential **effects of stopping** the medication with the parent/guardian providing consent. It is my clinical opinion that the person understands the information provided.

Signature of Prescribing Practitioner: _____ Date: _____

Parent/Legal Guardian (Print) :_____ Relationship to Recipient: _____

Phone Number: (Home): (____)_____ (Cell): (____)_____

☐ I consent to the use of the psychotherapeutic medication listed above.

☐ I do not consent to the psychotherapeutic medication listed above.

Comments:_____

_____

Signature of Parent/Legal Guardian: _____ Date: _____