

Recommendation and Authorization for Psychotropic Medication for Children in Foster Care

Date of appointment:

**Section A – Psychotropic medication recommendation:
(to be completed by licensed medical professional and reviewed with parents)**

Identifying information:

Child's name:	Child's TIPS Number
Prescribing health care provider:	Provider telephone number:

Clinical information: (to be completed by licensed medical professional)

Concurrent medical diagnoses, prescriptions and drug allergies:

All mental health diagnoses:

All current psychotropic medication:

Medication/dosage/ administration schedule	Medication/dosage/ administration schedule	Medication/dosage/ administration schedule

Discontinued psychotropic medication:

New medications and recommendations:

Name of medication:	Dosage/route/frequency of administration:
Target symptoms for treatment:	Potential side effects or drug interactions with other medicines:
Tests/procedures/labwork required before/during medication regimen: Alternative treatments attempted:	Results of alternative treatments:
Potential side effects reviewed with child: <input type="checkbox"/> Yes <input type="checkbox"/> No	Potential side effects reviewed with foster caretaker: <input type="checkbox"/> Yes <input type="checkbox"/> No Foster caretaker(s) name: Date Reviewed:

Name of medication:	Dosage/route/frequency of administration:
Target symptoms for treatment:	Potential side effects or drug interactions with other medicines:
Tests/procedures/labwork required before/during medication regimen: Alternative treatments attempted:	Results of alternative treatments:
Potential side effects reviewed with child: <input type="checkbox"/> Yes <input type="checkbox"/> No	Potential side effects reviewed with foster caretaker: <input type="checkbox"/> Yes <input type="checkbox"/> No Foster caretaker(s) name: Date Reviewed:

Signature: (Prescribing licensed medical professional) _____

Date: _____

Section B – Notification: (to be completed by caseworker)

Parent(s) were notified of recommended psychotropic medication(s), recommended dosage and frequency of administration, child symptoms targeted for treatment with the medication, and potential side effects: Yes No

Date Notified:

Parent(s) Comments:

**Section C – Child or young adult mental health assessment and placement information:
(to be completed by caseworker)**

Required - A mental health assessment (BH-1) must be completed before any new psychotropic medication or any antipsychotic medication is prescribed.

Date of most recent mental health assessment/update:

Urgent medical need for currently recommended psychotropic medication:

Date urgent need episode began: _____

Describe urgent medical need: *(include information on any treatment facility or licensed health care professional providing care):*

Placement setting:

Placement: Relative/Family Friend Foster Family Residential

Hospital / Psychiatric or Medical Other _____
(circle one) (specify)

**Section D – Administration of psychotropic medications:
(to be completed by parent, legal guardian or legal custodian)**

By signing below, I acknowledge authorization for the administration of _____
(name of medication(s))

has been provided by:

Parental/Legal Guardian Consent

Court Ordered treatment

Legal Custodian Consent *(when parents rights have been terminated/and when unable to identify or locate parents)*

for _____ (Child's Name) to receive the medications listed above,
as recommended by his/her licensed health care provider. Re-authorization due in six months, on or by
_____(specify date).

Note: As soon as the parent(s) are identified and/or located, authorization should immediately be obtained.

OR

By signing below, I **deny** authorization for _____ (child's name) to receive the
medications as recommended by his/her health care provider. Reason consent denied: **(If consent is denied, reason
must be provided below.)**

Signature of child's parent(s), legal guardian, or legal custodian (attach court order if court authorized) (Date)

Print name of child's DCFS Caseworker:

DCFS Caseworker email:

DCFS Caseworker office address:

DCFS Caseworker phone number: