Maryland
Department of Human Services
SOCIAL SERVICES ADMINISTRATION

PSYCHOTROPIC MEDICATION INFORMED CONSENT

SECTION A	PSYCHOTROPIC MEDICATION RECOMMENDATION: (to be completed by licensed medical professional)						
Child's Name:					Date of Visit:		
Gender:			DOB:		Known Allergies:		
Height:		Weight:		Blood Pressure:		Pulse:	

Placement Type:	☐ Kinship Home	☐ Foster Home	☐ Residential Program	☐ Independent Living	☐ RTC	☐ Other:

Placement Facility/Agency Name:	Contact Person:	Phone:
Prescriber Name:	Specialty:	Phone:
Office Address:		

Current Psychiatric Diagnoses *(check all that apply)*

☐ Autism	☐ Conduct Disorder	☐ Obsessive Compulsive Disorder
☐ MR/DD/PDD	☐ Oppositional Defiant Disorder	☐ Disruptive Mood Dysregulation Disorder
☐ Traumatic Brain Injury	☐ Bipolar Disorder	☐ Psychotic Disorder NOS
☐ Tourette's Syndrome	☐ Depressive Disorder	☐ Schizophrenia
☐ Down Syndrome	☐ Anxiety Disorder	☐ Panic Disorder
☐ ADHD	☐ Mood Disorder	☐ Other (please specify):
☐ Learning Disability	☐ Post-Traumatic Stress Disorder	

Current Medical Diagnosis *(check all that apply)*

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

The Child current has a ☐ 504 or ☐ IEP for one of the above diagnoses. Unknown: ☐

Prior psychiatric hospitalizations, evaluations, and psychotropic medications, if known:

Current Psychotropic Medications				☐ No Current Meds
Medication	Dosage	Time period given	Purpose	Discontinue?

Other medical medications or over the counter				
Medication	Dosage	Time period given	Purpose	Discontinue?

List any side effects/adverse reactions to previously prescribed psychotropic and non-psychotropic medications:

New Psychotropic Medications and Recommendations *(not necessary for dosage changes of a current medication if within the guidelines)*		
☐ New ☐ Dose-Change ☐ Renewal ☐ Emergency	☐ New ☐ Dose-Change ☐ Renewal ☐ Emergency	☐ New ☐ Dose-Change ☐ Renewal ☐ Emergency
Medication 1:	**Medication 2:**	**Medication 3:**
Dosage Range:	Dosage Range:	Dosage Range:
Is Dosage outside of FDA-approved guidelines: Yes: ☐ No: ☐	Is Dosage outside of FDA-approved guidelines: Yes: ☐ No: ☐	Is Dosage outside of FDA-approved guidelines: Yes: ☐ No: ☐
Frequency:	Frequency:	Frequency:
Use/Purpose:	Use/Purpose:	Use/Purpose:
Potential Side Effects:	Potential Side Effects:	Potential Side Effects:
Required Labs/Procedures (prior, during, after regimen)	Required Labs/Procedures (prior, during, after regimen)	Required Labs/Procedures (prior, during, after regimen)
Alternative Treatment Options:	Alternative Treatment Options:	Alternative Treatment Options:

Are any of the above medications prescribed as off-label usage? ☐ Yes ☐ No
If yes, explain:

Is there a recommendation for concurrent non-pharmacological treatment for the youth? ☐ Yes ☐ No

If yes, is the youth receiving the concurrent non-pharmacological treatment at the recommended frequency ☐ Yes ☐ No **and duration** ☐ Yes ☐ No

Comments:

I have discussed the above information with the child or young adult in a developmentally appropriate manner and they acknowledged understanding.	☐ Yes	☐ No
Did the child object to this medication? Explain if child provided a reason for objection?	☐ Yes	☐ No

I have reviewed all the above Information with the following person(s)

☐ Not applicable

Parent/legal guardian(s)	Parent(s) Name(s):	☐ Yes	☐ No
LDSS Worker	Worker's Name:	☐ Yes	☐ No
Kin Family	Kin family Name(s):	☐ Yes	☐ No
Resource Parent(s)	Resource Parent(s) Name(s):	☐ Yes	☐ No
Program Staff:	Program Staff:	☐ Yes	☐ No

If not a Psychiatrist, was there a consultation with a Psychiatrist or BHIPP?	☐ Yes	☐ No	Name of individual consulted with: Notes:

TO BE COMPLETED BY PRESCRIBING PROVIDER

_____ _____

Print Name of Prescribing Medical Professional Date Completed/Signed

_____

Prescribing Medical Professional Signature

SECTION B	CONTACT AND/OR NOTIFICATION TO PARENT/LEGAL GUARDIAN/ HEALTH CARE DECISION MAKER (to be completed by LDSS worker when LDSS is not the HCDM)

For children in the temporary custody of the LDSS, the administration of psychotropic medications requires the signed consent of a parent or legal guardian, the court, or the local department of social services. However, the LDSS can only consent if a court order explicitly authorizes it.
*It's important to note that foster parents do not have the authority to consent to the administration of psychotropic medications.

Child Name:	DOB:	Legal Status:	CJAMS PID #:

Parent/legal guardian was notified of the scheduled medical appointment, where psychotropic medication could be prescribed? ☐ Yes ☐ No
If no, why?
If so, prescriber contact information was shared ☐ Yes

Parent or legal guardian was notified of a recommendation for psychotropic medication? ☐ Yes ☐ No
If no, why?

If notification was not required, please explain:

Parent/legal guardian's Name:	Date of Contact/Attempt #1: Date of Contact/Attempt #2:	Contact Method #1: ☐ Call ☐ Text ☐ In Person ☐ Email ☐ Letter Contact Method #2: ☐ Call ☐ Text ☐ In Person ☐ Email ☐ Letter
Parent/legal guardian's Name:	Date of Contact/Attempt #1: Date of Contact/Attempt #2:	Contact Method #1: ☐ Call ☐ Text ☐ In Person ☐ Email ☐ Letter Contact Method #2: ☐ Call ☐ Text ☐ In Person ☐ Email ☐ Letter

☐ Contact attempts were not successful.
☐ Contact with parent/legal guardian was made, but they declined or is unable to be involved in the informed consent process.

LDSS Worker to complete:
I have discussed with the caregivers and child their observations relevant to the request for the prescribed medication(s) and have reviewed the health passport and health file, and am in agreement with prescriber's medication recommendation: ☐ Yes ☐ No

_____ _____
Print Name of worker & Signature Date

Jurisdiction:

SECTION C	CONSENT FOR ADMINISTRATION OF PSYCHOTROPIC MEDICATION(S) signed by parent, legal guardian, youth 16+ or LDSS Director or Assistant Director (see Consent for Psychotropic Medications policy for details on who can consent):

I HAVE BEEN INFORMED OF:

- THE PRESCRIBER'S RECOMMENDATION UNDER SECTION A FOR THE YOUTH LISTED ABOVE;
- THE NATURE OF THE YOUTH'S CONDITION;
- THE RISKS AND BENEFITS OF TREATING THIS CONDITION WITH MEDICATION;
- ANY ALTERNATIVE MEANS OF TREATMENT; AND
- THE RISKS TO THE YOUTH IF THE CONDITION IS NOT TREATED; AND
- THE NEED FOR A NEW SIGNED CONSENT EVERY YEAR, WHEN A NEW MEDICATION IS STARTED, OR WHEN THE PRESCRIBED DOSAGE EXCEEDS THE RECOMMENDED DOSAGE.

☐ By signing below, I give consent for _____ to receive the medications listed in section A, as prescribed by a licensed health care provider. I understand that I can withdraw this consent as to any medication during treatment.

☐ By signing below, I **do not** give consent for _____ to receive the medications listed in section A, as prescribed by a licensed health care provider for the following reasons:

_____ _____
Authorized Signature Date

_____
Print Name
Relationship to Youth: _____

_____ _____
Authorized Signature #2 Date

_____
Print Name
Relationship to Youth: _____