

## 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	<u>(MM/D</u> D/YY <u>Y</u>	Y)							
Recipient's Full Name										
Prescriber's Full Name										
Prescriber License # (ME, OS, AR, PA)										
Prescriber Phone Number		Г	Prescribe	r Fax Num	iber	ı —				
						-				
Psychotherapeutic Medication  [antipsychotics, antidepressants, anti-anxiety, mood stabilizers (anticonvulsants and ADHD medications not included)]		Dose Range								
1.	·			1						
2		2						_		
Diagnoses:	Target Symptom(s):		Expected C	Outcome(s)	1:					
☐ I have discussed possible other treatmed ☐ I have discussed the reason for treatmed will be monitored with the parent/guard medication(s) including the possible side of stopping the medication with the partinformation provided.	ent(s), the expected outcorian providing consent. I have effects, the potential med	me(s), the appearance also discussilication inters	proximate le sed the bene actions, cor	ength of treefits and ris	sks of this <b>tions</b> and	s psychological the potential	therap ential	eutic effects		
Signature of Prescribing Practitioner:			Date:							
Parent/Legal Guardian (Print) :	Relationship to Recipient:									
Phone Number: (Home): ()	(Cell)	: <u>(</u> )								
☐ I consent to the use of the psychotheral	neutic medication(s) listed a	hove								
☐ I do not consent to the psychotherapeut										
T do not consent to the psychotherapeut	ic medication(s) listed above	ᠸ.								
Comments:										
Signature of Parent/Legal Guardian:			Date:							