Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

INFORMED CONSENT FOR PSYCHOTHERAPEUTIC MEDICATION

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

F.S. 409.912(16) The Agency may not pay for 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**. The express and informed consent or court authorization for a prescription of psychotropic medication for a child in the custody of the Department of Children and Families shall be obtained pursuant to s. 39.407.

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**
1. _____	1. _____
2. _____	2. _____

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

☐ I have discussed the **reason for treatment(s)**, the **expected outcome(s)**, 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(s) 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(s) listed above.

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

Comments:_____

_____

Signature of Parent/Legal Guardian: _____ Date: _____