



# 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 <small>[antipsychotics, antidepressants, anti-anxiety, mood stabilizers (anticonvulsants and ADHD medications not included)]</small>	Dose Range
1. _____ 2. _____	1. _____ 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: \_\_\_\_\_