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| PSYCHOTROPIC MEDICATION INFORMED CONSENT |
| Michigan Department of Health and Human Services |
| For Children in Foster Care and/or Juvenile Justice |
| **Section A – Identifying Information (completed by Child Welfare staff)** |
| Child/Youth Name | Date of Birth | Medicaid ID # | MiSACWIS Person ID # |
|       |       |       |       |
| Legal Status | Current Placement Date | Placement Type |
|       |       |       |
| Authorized Consenter(s) | Relationship to Child/Youth | Contact Phone |
|       |       |       |
|  |  |  |
|       |       |       |
| Caseworker | Caseworker Phone | Agency |
|       |       |       |
| **Consents on File** |
| Medication | Maximum Dose | Annual Review Due | Discontinued |
|       |       |       |       |
|       |       |       |       |
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| **Section B – Health Information (completed by medical provider or medical staff)** |
| Physician Name | Phone | Appointment Date |
|       |       |       |
| Location of Appointment |
|       |
| Mental Health Diagnoses |
|       |
| **Section C – Medication Recommendations (completed by physician or medical staff)** |
| Medication Name | Recommended Dosage Range (maximum) | Check applicable box: |
| New | Dose exceeds prior consent | Annual Review | No change |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
|       |       | [ ]  | [ ]  | [ ]  | [ ]  |
| I recommend the above listed medications for the treatment of this patient’s symptoms. I have discussed the clinical diagnosis, reason for the medications, alternative treatments, possible side effects, and baseline/ongoing testing recommended with the party indicated as the authorized consenter for this patient. |
| Physician Signature | Date |
|  |  |
| **Section D – Youth Attestation Physician: If youth unable to attest, check here** **[ ]  and initial:**  |
| The physician talked with me about the above medications, and I have had the chance to ask questions. |
| Youth Signature | Date |
|  |  |
| **Section E – Consent (completed by consenting party listed in Section A)**  |
| My signature indicates I give consent for the use of medications listed in Section C identified as **NEW, DOSE EXCEEDS PRIOR CONSENT AND/OR ANNUAL REVIEW** and that the doctor discussed the:* **DIAGNOSIS, TARGET SYMPTOMS, REASON FOR MEDICATIONS,**
* **OTHER ALTERNATIVE TREATMENTS,**
* **POSSIBLE SIDE EFFECTS,**
* **ANY TESTING NEEDED BEFORE OR WHILE ON THE MEDICATIONS.**

I hereby agree to the doctor’s recommendations. This consent is voluntary, and I am aware that I can withdraw consent at any time, with written notification, during treatment. This consent expires after 1 year and a new consent is required if the treatment plan is continued. |
| Signature | Print Name | Date |
|  |  |  |
| [ ]  Discussed with physician in person | [ ]  Discussed with physician via telephone | [ ]  Physician provided written documentation |
| For Foster Care Only:Questions: Call 844-764-PMOU (7668)Caseworkers: upload in MiSACWIS – attached to the “Health-Medication-Informed Consent screen.”Clinical personnel: email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to: 517-763-0143. |
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