



Illinois Department of Children & Family Services

PSYCHOTROPIC MEDICATION REQUEST FORM

Date _____ Child's Name _____ DCFS ID# _____ (8digits)

Age of Birth _____ Male Female Ethnicity _____ Current Height _____ Weight _____

Placement: Foster Care Residential DOC Hospital Family of Origin Other _____

Facility Name _____ Address _____ Telephone _____

Prescribing Physician _____ Specialty _____ Telephone _____ Fax _____

Check DCFS/POS Region Cook County Northern Central Southern

Clinical Information

Concurrent Medical Diagnoses: _____

Psychiatric Diagnosis: _____

Current Psychotropic Medications

Medication/Dosage/Frequency _____ Medication/Dosage/Frequency _____ Medication/Dosage/Frequency _____

Medication/Dosage/Frequency _____ Medication/Dosage/Frequency _____ Medication/Dosage/Frequency _____

Discontinued Psychotropic Medications: _____ Medication/Dosage/Frequency _____

Additional Info/Other Medications: _____

Medication Request

Check One: New Increase* 180 Day Renewal* Resume One Time Order New Ward, Current Medication

**If medication request is for an Increase or Renewal include the current dosage in the Clinical Information section.*

Brand Name _____ Chemical Name _____

Form _____ Dosage _____ Frequency _____ Range _____ Duration (not to exceed 180 days) _____

Symptoms for Medication Requested: _____

Tests/Procedures prior to and to monitor medication requested: _____

Alternative Treatment/Medications*: _____

**List alternative treatment methods and medications considered/attempted and the reasons they failed or were rejected.*

Potential side effects reviewed with child? Yes No If the child is 12 years of age or older, does he/she object to medication? Yes No

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