CFS 431-A

Illinois Department of Children & Family Services

PSYCHOTROPIC MEDICATION REQUEST FORM

Child's Name ____________________________ DCFS ID# (8digits) __ __ __ __ __ __ __ __ ❑ Male ❑ Female Date ______________

Date of Birth _______________ **If 18 or older, include either consent from youth or continued guardianship court order** Ethnicity _________

Placement type: ❑ Foster Home ❑ Residential ❑ Hospital ❑ Family of Origin ❑ Shelter ❑ DOC ❑ Other_______________________

Facility or Agency Name _______________ Contact Person __________________ Phone ___________________ Fax ______________

Prescriber _____________________________ Specialty ________________ Phone __________________ Fax ___________________

Clinical Information

Psychiatric Diagnoses (include r/o): ____

____

Medical Diagnoses: ____

Current Psychotropic Medications ❑No Current Meds

*include all current meds & dosages, meds on without consent and those being renewed

____ ❑ to be discontinued
Medication Dosage Time Given

____ ❑ to be discontinued
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Past trials/reason for discontinuation:____

____

____

Other current medical medications, over the counter and supplements: _____________

____

Current weight _______ **Current height** _______

Date wt. and ht. last taken ______________

Tests to be Monitored: Include Results and Date

❑ FBS ______________ ❑HgAIC________________

❑ Lipids ____________ ❑ Na ___________________

❑ K+_______________ ❑ Mg++________________

❑ EKG_____________ ❑ VPA level ______________

❑ LiCO3 level ___________ ❑ CBZ level __________

❑ LFT's ______________ ❑ TFT's ________________

❑ Kidney _____________ ❑Other: ______________

Will Monitor: Include Comments and Plan

❑ Adequate Growth __________________________

❑ Excessive Wt. Gain _________________________

❑ AIMS/DISCUS_____________________________

❑ Other ____________________________________

Medication Request (all fields required for processing)

Type of request: ❑ New ❑ Increase ❑ Renewal (consent to expire) ❑ Resume (prior trial) ❑ New ward, current med ❑ One Time Order
❑ Emergency med (for acute sx's) ❑ On med or dosage w/o consent; Prescriber who started med ______________ Date started ___________

Medication __________________________ Dosage __________ Times Given _______________ Range ________ Form_______ Duration ________
NOT TO EXCEED 180 DAYS

Symptoms/Behaviors for this medication (do not list diagnoses, acute = current; remitted = controlled on medication):

❑ This Medication is to treat acute symptoms; List Current Symptoms: ____

____

❑ This Medication is for maintenance treatment; List Remitted Symptoms:____

____

Additional rationale for co-pharmacy, non-first-line medications, polypharmacy and other significant clinical information i.e. explanation of the treatment plan or history, alternative treatments (required for children <8), etiology of sleep disturbance. List all current adverse/side effects.

____

____

Side effects for all medications reviewed with child?	❑YES ❑NO	Does child object to the medication?	❑YES ❑NO	____________________ IF YES, LIST MEDICATION AND EXPLAIN WHY CHILD OBJECTS

Form Completed by:	❑MD Office ❑ Facility Staff ❑ DCFS worker ❑ POS worker ❑ Agency ❑ Other______________________ Name ___________________________________ Phone ___________________ Fax _________________	**Number of pages:** _____

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Instructions: Page 2 is for additional medication requests. **PAGE 1 MUST BE SENT** with any additional pages. To assure all pages are received, complete the following: INITIALS (of sender) ______PHONE NUMBER _____________ FAX NUMBER____________ DATE: ______________CHILDS NAME ____________________________DCFS ID __ __ __ __ __ __ __ __

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Type of request: ❑ New ❑ Increase ❑ Renewal (consent to expire) ❑ Resume (prior trial) ❑ New ward, current med ❑ One Time Order ❑ Emergency med (for acute sx's) ❑ On med or dosage w/o consent; Prescriber who started med ______________Date started ___________

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