Clinical Services in Psychopharmacology

CFS 431-A, Rev. 12/2011, Form Instructions:

General:

- Complete all fields on page 1. Page 1 should always be included.
- If more than one medication is requested, complete and send page 2.
- If a medication is started without consent it is mandatory that the original prescriber is listed.

<u>Page 1</u>

Section I: Demographics:

CFS 431-A **Illinois Department of Children & Family Services**

<u>PSYCHOTROPIC MEDICATION REQUEST FORM</u>

1.Child's Name ________________________2.DCFS ID# (8digits) ________________ 3.❑ Male ❑ Female Date ___________

4.Date of Birth ___________**If 18 or older, include either consent from youth or continued guardianship court order** 5.Ethnicity ________

6.Placement type: ❑ Foster Home ❑ Residential ❑ Hospital ❑ Family of Origin ❑ Shelter ❑ DOC ❑ Other__________________

7.Facility or Agency Name ____________8.Contact Person ______________Phone _________________Fax ____________

9.Prescriber _________________________10.Specialty ____________Phone _________________Fax __________________

1. **Child's Name** Correct spelling of name, aliases, and hyphenated last names; do not assume all names are spelled the same, i.e., John or Jon.
2. **DCFS I.D. #** Is an 8digit number that would not end in <u>00</u>
3. **Gender** Some names are not gender specific. There are some side effects that should be reported to DCFS that are gender specific.
4. **Date of Birth** Age can determine appropriate use and dosage of a medication. It is also useful in assessing proper growth and development. Consultations are accepted for DCFS wards under the age of 18 years old unless DCFS has been given authority to consent for meds in a court of law. If an 18 year old requests for a DCFS consultants opinion a written consent from the youth must accompany this form.
5. **Ethnicity** May influence the metabolism and possible side effects of some medications.
6. **Placement** Check where the child resides at the time of the request for medication.
7. **Facility or Agency Name** Include the name of the hospital, residential, group home, detention center etc. or the agency that is providing services for foster care.
8. **Contact Person and contact information** Provide the name, telephone and fax number for the person that can provide information or expedite communication between the CSP consultant and the prescribing clinician.
9. **Prescriber** Correct, legible spelling of prescribers first and last name.
10. **Specialty and contact information** The prescribers area of specialty, i.e., psychiatrist, pediatrician, family practitioner, pediatric neurologist, advanced practice nurse or physician's assistant. The correct telephone and fax number will assist agent in obtaining up to date and correct information and return consent to the provider as quickly as possible.

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Section II: Relevant Clinical Information

Clinical Information

1.Psychiatric Diagnoses (include r/o): ______________________________

____

2.Medical Diagnoses: ______________________________

3.**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

Medication Dosage Time Given

______________________________ ❑ to be discontinued

Medication Dosage Time Given

______________________________ ❑ to be discontinued

Medication Dosage Time Given

______________________________ ❑ to be discontinued

Medication Dosage Time Given

______________________________ ❑ to be discontinued

Medication Dosage Time Given

______________________________ ❑ to be discontinued

Medication Dosage Time Given

4.Past trials/reason for discontinuation:______________________________

____

____

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

____

5.**Current weight** _____**Current height** ________

Date wt. and ht. last taken ______________

6.**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: ____________

7.**Will Monitor:** Include Comments and Plan

❑ Adequate Growth ____________________

❑ Excessive Wt. Gain ____________________

❑ AIMS/DISCUS____________________

❑ Other ____________________

1. **All Psychiatric Diagnosis** All current DSM psychiatric diagnosis should be listed. Medication management follows diagnosis.
2. **Concurrent Medical Diagnosis** All current medical conditions, i.e., asthma, diabetes, obesity. This assists with identifying potentially contraindicated treatments.
3. **All current medications and dosages**
   - ✓ Check NO CURRENT MEDS box if appropriate. If left blank a follow up call will be needed to assure that the data is correct.
   - ✓ List **all** of the current medications and dosages and time given, especially if medication request is for a higher dose.
   - ✓ Check TO BE DISCONTINUED if the plan is to taper and discontinue the current medication. Proceed to next section to provide rationale for discontinuing.
4. **Past Trials and reason for discontinuation** Adequate trials is an essential part of the medication history. For all discontinued medication fill out the reason for discontinuation (i.e. ineffective, side effects, non-formulary, patient refuses etc.) For past trials include maximum dose and duration of trial.
5. **Weight and Height and Date last taken** Accurate weight at time of consent request will be used to calculate the appropriate dose of the medication. Height is necessary to assess adequate development as some medications may effect growth. Date is essential to assess growth and accuracy of data.
6. **Test** List all pertinent tests needed to safely monitor minor on medications. Include date last taken and results. Include current Lithium Carbonate, Valproic Acid and Carbamazepine serum blood levels whenever requesting increases or renewals.

7. **Will monitor** Indicates that prescriber is monitoring potential or current adverse effects or related health issues. Please include any comments or a plan i.e. Nutrition and exercise plan in place.

Section lll: Psychotropic Medication Request

8. **Type of request**

Medication Request (all fields required for processing)

8.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 ___________

- ✓ ***New*** medication request for minor.
- ✓ ***Increase*** in actual dosage or range. Must include the current dose of medication being requested.
- ✓ ***Renewal***- Six-month evaluation to assess the need for continued use of the requested medication. The renewal request should consist of current symptoms or past exhibited behaviors that medication has stabilized. Give the current dosage and maximum dosage range if still indicated.
- ✓ ***Resume***- A medication that was discontinued; however, symptoms indicate need for medication to be restarted. Please include explanation under additional rationale i.e. Minor refused medication one month ago however is asking to restart medication due to a regression in mood.
- ✓ **New Ward, Current Medication** A medication that was started prior to wardship and will continue under the observation of the child's current or new M.D. and placement. If known, list when medication was started under additional rationale.
- ✓ ***One Time Order*** Check if a planned event or procedure requires a medication to complete. i.e. EEG, dental appointment requiring sedation.
- ✓ **Emergency Medication** Per the Mental Health and Developmental Disabilities Code (MHDD Code), emergency medications are permitted if a minor is a threat to themselves or to others. In addition to completing all the fields on this form please **add route, date and time given.**

*Note: PRN consents are not granted by DCFS, One Time Orders are reviewed for **one** dose of the stated medication.*

- ✓ **On medication or dosage without consent** Check if a medication was started or increased without the consent of DCFS. The name of the prescriber who started or adjusted the medication without consent should be listed as well as the date the medication was started.

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9.Medication ________________________ 10.Dosage ________ 11.Times Given ____________ 12.Range ______ 13.Form _____ 14.Duration _______ Not to Exceed 180 Days
15.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: ____

____

16.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.

____

____

9. **Medication** Should be written legibly.
10. **Dosage** Starting dose if new, current dose if renewal, increased dose if increase.
11. **Times Given** List the times the medications are being given. If the plan is to increase the number of dosage times, list it as starting dose up to target frequency. i.e. 8pm up to 3x/day or tid.
12. **Range** May request a maximum dose for this child's age and wt.
13. **Form** Indicate the form the medication will be given. i.e. Tablet or elixir, IM or PO
14. **Duration** The duration of the request is for 180 days unless indicated differently by the prescriber (i.e., One time orders or for 2 weeks).
15. **Symptoms or Behaviors for this medication** Rationales should ***not*** be Drug Classifications or a Psychiatric Diagnosis. Symptoms should be clear and descriptive. All symptoms must correspond with the treatment requested and should refer to a previously listed psychiatric diagnosis.
    - ✓ **Current symptoms** List all current or acute symptoms the minor is still having.
    - ✓ **Remitted symptoms** List all the minors symptoms that the medication is currently controlling.
16. **Additional Rationale** A place to put your specific rationales for difficult to treat cases or other information you may feel will help us to understand the medication regimen for this child.
    - ✓ List specific rationales for the following:
        a. Co-pharmacy,
        b. poly-pharmacy
        c. Non-first-line medications.
    - ✓ Provide additional information:
        d. Treatment plan or history
        e. Etiology of sleep disturbance
    - ✓ Essential information to add:
        f. Alternative treatments (helpful for all minors but required for minors under age 8.) List other therapies, education or behavioral interventions planned (when will it be intiated), tried (how long and benefits) and failed (when and why was it terminated.)
        g. List all current adverse or side effects.

Section IV: Informed consent and contact information

17.Side effects for all medications reviewed with child?	❑YES ❑NO	18.Does child object to the medication?	❑YES ❑NO	IF YES, LIST MEDICATION AND EXPLAIN WHY CHILD OBJECTS
19.**Form Completed by:**	❑MD Office❑ Facility Staff ❑ DCFS worker❑ POS worker❑ Agency❑ Other_______________		1	20.**Number of**

17. **Side effects for all medications reviewed with child** Check yes if side effects for all medications being requested has been reviewed with the child. If no, indicate the plan for following this standard of care.
18. **Does the child object to the medication** Check no if the minor does not object to taking the medication. Check yes if the minor objects and explain why he/she objects in the space provided.
19. **Form completed by:** For expediting processing your request form, indicate who has completed the form and all of the related contact information.
20. **Number of pages:** if only one medication is being requested add "1" and send 1st page only. If more than one page is needed than indicate how many pages are being sent.

Page 2

- Page one must always be included.

CFS 431-A
Rev 12/2011

Illinois Department of Children & Family Services
PSYCHOTROPIC MEDICATION REQUEST FORM

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 __ __ __ __ __ __ __ __

- Include initials and contact information in the case that the request is separated.
- Include the date, child's name and DCFS ID to reference page 1 of your request should pages get separated.
- Continue your medication requests on page 2.