

1. **Child's Name**  
Correct spelling of name, aliases, and hyphenated last names; do not assume all names are spelled the same, i.e., Johnathan or Jonathon
2. **DCFS I.D. #**  
Is an 8digit number that would not end in 00
3. **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.
4. **Gender**  
Some names are not gender specific. There are some side effects that should be reported to DCFS that are gender specific.
5. **Ethnicity:** May influence the metabolism and possible side effects of some medications.
6. **Weight and Height**  
Accurate and current 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.
7. **Placement**  
Check where the child resides at the time of the request for medication.
8. **Facility Name**  
The name of the facility, along with address and telephone number will assist agent to obtain up to date and correct information as quickly as possible.
9. **Prescribing Physician**  
Correct legible spelling of physician name.
10. **Specialty and contact information.**  
The prescribing physician's area of specialty, i.e., psychiatrist, pediatrician, family practitioner, pediatric neurologist. An address and telephone number will assist agent in obtaining up to date and correct information as quickly as possible.
11. **Region**  
Check the Region that the child's DCFS/POS agency resides in.
12. **Concurrent Medical Diagnosis**  
All current medical conditions, i.e., asthma, diabetes, obesity
13. **All Psychiatric Diagnosis**  
All current DSM psychiatric diagnosis should be listed. Medication management follows diagnosis.
14. **All current medications and dosages**  
List **all** of the current medications and dosages, especially if medication request is for a higher dose.
15. **Discontinued Medication**  
List all discontinued medication and medications that will be tapered to be discontinued if the requested medication is approved.
16. **Additional Info/other medications**

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. Include medications for medical purposes as they may be contraindicated in conjunction with some psychotropic medications.

**17. Medication information**

**New** medication request for minor. Please indicate if this is a **New Ward** that is already on medication.

**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.

**One Time Order**- Emergency or Stat medication requests. Per the [Illinois Mental Health 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.*

**18. Brand Name and Chemical Name**

Should be written legibly

**19. Form**

Indicate if the medication is a tab, liquid etc.

**20. Dosage**

Starting dose if new, current dose if renewal, increased dose if increase. Also add dosage range if indicated.

**21. Frequency**

List the times the medications are being given, i.e., bid, tid, qid, qd, qhs. If starting qd and then increasing frequency may enter qhs up to tid.

**22. Range**

May request a maximum dose for this child's age and wt.

**23. Duration**

The duration of the request is for 180 days unless indicated differently by the prescribing physician, i.e., One time orders or for 2 weeks

**24. Symptoms or Rationale for medication requested**

Symptoms should be clear and descriptive and in the case of renewals may be listed as a past history of behaviors. All symptoms must correspond with the treatment requested and should be referable to psychiatric diagnosis.

Rationales for co-pharmacy, poly-pharmacy or unusual medication regimens are required with each and every request. Include current Lithium Carbonate, Valproic Acid and Carbamazepine serum blood levels whenever requesting increases or renewals.

Rationales should **not** be Drug Classifications or a Psychiatric Diagnosis.

**25. Alternative treatment methods considered/attempted and the reasons they failed or were rejected**

This section allows the prescribing physician to list previous medications, therapies or behavior interventions that have been tried and/or have failed.

**26. Test/procedures required**

List all pertinent tests needed to safely monitor minor on medications, i.e., EKG, serum blood levels, labs, B/P, P

**27. Potential side effects**

Check if side effects have been reviewed with the child.

**23. If child is 12 years of age or older, does he/she object to medication**

Per the [Illinois Mental Health Code](#) all children 12 years or older have the right to refuse prescribed medications