Clear

PSYCHOTROPIC MEDICATION TREATMENT PLAN REVIEW

Pre-Psychotropic Medication Consent Review for Children Under Eleven (11) Years of Age, in the Custody of the Department in Out-of-Home Care and Prescribed Two (2) or More Psychotropic Medications

Prescribing Practitioner's Name:

_____
First Last

Prescriber's Specialty: ☐ Pediatrician ☐ Child Psychiatrist ☐ General Psychiatrist ☐ Other

Address: _____
Street

_____
City State Zip

Phone Number: _____, ext. _____

Fax Number: _____

SECTION 1: DEMOGRAPHIC INFORMATION (to be completed by the Child Case Manager / Child Welfare Worker)

Child's Name: _____ **Date of Office Visit:** _____

Address:

Child's Date of Birth: _____ Age: _____

Child's Height: _____ Weight: _____

Child's Gender: ☐ Male ☐ Female

DCF Region/Circuit: _____

Case Manager/Child Welfare Staff: _____ Phone Number: _____

Case Manager Supervisor: _____ Phone Number: _____

DCF Contracted Agency: _____ Fax Number: _____

Obtaining Informed Consent was attempted from the parent/guardian: ☐ YES ☐ NO Date: _____

Person Consulted: _____ Relationship to Child: _____

Please Explain: _____

Sections 2 through 5 are to be completed by the Prescribing Practitioner

SECTION 2: DIAGNOSIS / DISORDER / BEHAVIORAL HYPOTHESIS

☐ Depression	☐ Oppositional Defiant Disorder	☐ ADHD	☐ Anxiety Disorder
☐ Conduct Disorder	☐ Post Traumatic Stress Disorder	☐ Substance Abuse	☐ Mental Retardation
☐ Substance Abuse	☐ Reactive Attachment Disorder	☐ Bipolar Disorder	☐ Autism/Asperger's
☐ Psychosis	☐ Learning Communication/Speech	☐ Other: (specify) _____	

☐ Rule Out: _____

SECTION 3: PSYCHOTROPIC MEDICATIONS PLANNED

Medication: _____ Dose Amount: _____ Unit: _____ (e.g., mg)

Route: _____ (e.g., p.o.) Frequency: _____ (e.g., BID) Dosage Range: Starting Dose: _____ Maximum Dose: _____

Titration Plan: _____

_____

Start Date: _____ to address the following target symptoms: 1) _____ 2) _____

3) _____ 4) _____ 5) _____ 6) _____

Define treatment success/failure: _____

Define monitoring plan (include frequency of planned monitoring): _____

If the above medication fails to meet the identified goal, the following medication in the same drug class will be tried:

Medication: _____ Dose Amount: _____ Unit: _____ (e.g., mg)

Route: _____ (e.g., p.o.) Frequency: _____ (e.g., BID) Dosage Range: Starting Dose: _____ Maximum Dose: _____

Titration Plan: _____

_____

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Prescribing Practitioner's Name:

_____
First Last

Child's Name:

_____
First Last

Date/time of Office Visit:_____/_____/_____ _____ ☐ AM ☐ PM

Date/time faxed to UF:_____/_____/_____ _____ ☐ AM ☐ PM

Section 3: PSYCHOTROPIC MEDICATIONS PLANNED (continued from page 1)

Additional Supporting Information:_____

_____

SECTION 4: OTHER PLANNED TREATMENTS / THERAPIES / EVALUATIONS / TESTS (Please list provider(s))

_____

_____

SECTION 5: MEDICAL PROBLEMS AND OTHER MEDICATIONS (including over-the-counter medications)

Medical Problems: 1)_____ **2)**_____ **3)**_____

Other Medications: 1)_____ **2)**_____ **3)**_____

Over the counter medications: 1)_____ **2)**_____

Signature of Prescribing Practitioner / Date

Section 6 is to be completed by the UF Consultant Child Psychiatrist

SECTION 6: PSYCHOTROPIC MEDICATION TREATMENT PLAN REVIEW

Disclaimer: The findings and analysis herein are based on the information provided in Sections 1-5.

UF Child Psychiatrist Review (check one):

☐ **I concur with the treatment plan listed by the attending prescribing practitioner in Section 3.**

☐ **I concur with the treatment plan in Section 3 with the following modifications that I have discussed with the prescribing practitioner:**_____

_____

☐ **I need the following information to provide an opinion about this child's psychotropic medication treatment plan:**

_____

_____

☐ **I do not concur with the identified treatment plan.**

Phone consultation between:_____ and _____
Prescribing Practitioner/Title UF Child Psychiatrist

Date/Time:_____

Other Contact History:_____

Contact 1:_____

Contact 2:_____

Contact 3:_____

University of Florida, School of Medicine, Department of Psychiatry
MedConsult: Phone number: 866-453-2266
MediConsult: Fax number: 352-846-1455

_____
UF Child Psychiatrist's Signature / Date

Date and time faxed to the child's case manager:_____

E-mail notification of fax sent to:_____