Prescribing Psychotropic Medication
Children in Out-of-Home Care

MEDICAL REPORT

OPTION FOR PHYSICIAN:

YOU MAY SUBSTITUTE A MEDICAL REPORT PREPARED BY YOUR OFFICE AS LONG AS THE MEDICAL REPORT SUBSTITUTED ADDRESSES ALL ELEMENTS IN THIS REPORT. PLEASE NOTE THAT IF A COURT ORDER IS NEEDED TO ADMINISTER THIS MEDICATION, SOME JUDGES MAY ASK FOR ADDITIONAL INFORMATION.

Dear Physician:

The attached Medical Report has been developed to guide the treatment of children in the custody of the Florida Department of Children and Families who are prescribed a psychotropic medication. These children are not residing with their parent or legal guardian.

- ❍ Prior to prescribing a psychotropic medication, s. 39.407, F.S., requires the prescribing physician to attempt to obtain express and informed consent from the child's parent or legal guardian. This is required even when the medication is prescribed for medical reasons unrelated to behavioral healthcare.
- ❍ In the absence of the parent's express and informed consent or in emergency situations, the completed and signed Medical Report will be submitted to the court and admitted into evidence at a hearing. The information in the report will be used in lieu of a court appearance by the physician. Therefore, it is critical that all information contained in the report be complete and thorough.
- ❍ Express and informed consent may only be given by the child's parent or legal guardian. In no case may the dependency case manager, child protective investigator, or the child's caregivers provide express and informed consent for a child to be prescribed a psychotropic medication.

Florida Statute 39.407, F.S., requires physicians who prescribe psychotropic medications to children in out of home care to complete a medical report that includes the following information:

1. A statement indicating that the physician has reviewed all medical information which has been provided concerning the child.
2. A statement indicating that the psychotropic medication, at its prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, at its prescribed dosage, is expected to address.
3. An explanation of the nature and purpose of the treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible effects of stopping the medication; and how the treatment will be monitored, followed by a statement indicating that this explanation was provided to the child if age appropriate and to the child's caregiver.
4. Documentation addressing whether the psychotropic medication will replace or supplement any other currently prescribed medications or treatments; the length of time the child is expected to be taking the medication; and any additional medical, mental health, behavioral, counseling, or other services that the prescribing physician recommends.

Thank you for your work with children in the out of home care system.

An electronic version of this form can be downloaded from http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx, and the form can be filled in on-line, saved, and then return by email.

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THIS PAGE TO BE COMPLETED BY CASE MANAGER

SECTION 1: CHILD'S INFORMATION

Name		
	DOB	Gender

Case Manager's Name	Phone Number
Case Manager's Supervisor's Name	Phone Number
DCF Contracted Agency	FAX Number
Guardian Ad Litem	Phone Number
Child's Attorney	Phone Number
Primary Care Physician	Phone Number
Caregiver	Phone Number

☐ Foster Home ☐ Group Care/Residential ☐ Relative/Non-Relative Caregiver

☐ Child's parents' rights are intact and the parents or legal guardian may sign consent for psychotropic medications.

Mother's Name	Phone Number
Father's Name	Phone Number

☐ Court order for psychotropic medications will be sought if: parents refuse to consent for psychotropic medications, parents are not available to consent for psychotropic medications or the child is permanently committed to the Department.

The child has the following known medical conditions/diagnosis/chronic Illness:

The child has the following known food/drug allergies:

SECTION 2: INFORMATION PROVIDED TO PHYSICIAN

Briefly list any persons consulted, tests performed, and documents reviewed in conjunction with this child's evaluation. (NOTE: The dependency case manager is responsible for providing all pertinent medical information known to the Department concerning the child.)

Documents Provided: (check all that apply)

- ☐ Medical Records
- ☐ Current health status, health services, medications (FSFN Medication Screen Print Outs)
- ☐ Current Health Physical Exam/Child Well Check-up
- ☐ School Records (Diagnostic; report card, IEP)
- ☐ Past Assessments: Psychological, Psychiatric, CBHA, Behavioral Health Assessments
- ☐ Other (list):

Family/Child History of: (check all that apply)	Family (Fm)	Child (Cx)
Substance abuse	☐	☐
Non-compliance with medications	☐	☐
History/current of psychiatric hospitalization	☐	☐
Violence or threats to self or others	☐	☐
Depression	☐	☐
Social or Developmental Delays	☐	☐
Specific suicidal statements or actions	☐	☐
Psychiatric diagnoses	☐	☐
Current non-psychiatric medical condition	☐	☐
Recent change in mood or behavior	☐	☐
Mental health history	☐	☐
Academic or social difficulties	☐	☐
Running away	☐	☐
Domestic violence	☐	☐
Human trafficking	☐	☐
Traumatic experiences	☐	☐

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Child's Name: _____ DOB: _____

SECTION 3: MEDICAL INFORMATION (TO BE COMPLETED BY THE DOCTOR)

Date of Appointment: _____ Child's Height: _____ Child's Weight: _____

ICD-10* Code	Diagnosis	Symptoms

*ICD=International Classification of Diseases

List all medications new and current (including OTC medications)

Targeted ICD-10 Code(s)/Symptoms	Medication	Dosage	Titration	Dosage Range (max per day)	Indicate if: Continue, New or Dose Change
					☐ Continue ☐ New ☐ Dose Change
					☐ Continue ☐ New ☐ Dose Change
					☐ Continue ☐ New ☐ Dose Change
					☐ Continue ☐ New ☐ Dose Change
					☐ Continue ☐ New ☐ Dose Change

Medication(s) being discontinued, tapered or temporarily suspended: (Describe medication plan. If medications are substituted, indicate what new medication is replacing.)

Side effects, precautions, contradictions, and risks of stopping medications for the caregiver to monitor: ..... ☐ **Side effects to be attached**

Follow up visit frequency: ☐ Weekly ☐ Monthly ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ 6 Months ☐ Annually

The length of time the child is expected to be taking the medications is: _____

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Child's Name: _____ DOB: _____

Lab Monitoring / Other Tests needed: Check only those that apply ..... ☐ **N/A, Labs not recommended**

	Before start	Change in dose	Frequency		Before start	Change in dose	Frequency
☐ CBC ☐ with differential, ☐ w/o differential				☐ A.I.M.S.			
☐ Comprehensive metabolic panel				☐ Lithium level			
☐ Basic metabolic panel				☐ Electrocardiogram (ECG/EKG)			
☐ Urinalysis				☐ Depakote/Depakene level			
☐ Urine Toxicology Screen				☐ Neurological exam/assessment			
☐ Pregnancy test ☐ urine ☐ blood				☐ Lipid profile (HDL, LDL, Chol, Trig)			
☐ TSH				☐ Other Laboratory tests (specify):			

Additional medical, mental health, behavioral, counseling, or other services recommended by the prescribing physician:

Does child's medical history include conditions that may indicate the presence of brain injury? ☐ Yes ☐ No ☐ Further assessment needed

Describe condition or assessment needed:

Other health conditions considered (list):

Persons Consulted or interviewed regarding the child's history:

Name of Person Consulted	Title/Relationship to Child

I have discussed with the child the reason for treatment; the proposed treatment; the purpose of the treatment to be provided; the common risks, benefits, and side effects of the treatment; the specific dosage range for the medication; alternative treatment options; the approximate length of care; the potential effects of stopping treatment; and how treatment will be monitored.

☐ Child assents ☐ Child does not assent ☐ Child is not able to assent

Comments/reason for non-assent/inability to:

***CERTIFICATION OF SIGNIFICANT HARM.** *This section must be completed when it is likely that the delay in taking the prescribed medication would cause significant harm to the child.*

I hereby certify that delay in providing this prescribed psychotropic medication(s), _____, would more likely than not cause significant harm to the child for the following reasons:

_____.

For these reasons, this medication should be provided in advance of the issuance of a court order pursuant to Section 39.407(3)(e)(1), F.S.

***If this section is not completed, there is no emergent need for this medication(s) and medication SHALL NOT be administered prior to court order or parental consent.**

☐ **This child is currently in a hospital, crisis stabilization unit, or psychiatric residential treatment center.** I recognize that this finding statutorily *pre-authorizes* the Department to provide the proposed medication profile to the child immediately and prior to obtaining a court order. A court order must then be sought within three (3) business days

MEDICAL REPORT

Child's Name: _____ DOB: _____

SECTION 4: PHYSICIAN'S CERTIFICATION: By completing and signing this report, I hereby certify the following to be true and accurate:

- An explanation of the nature and purpose of treatment; the recognized side effects, risks, and contraindications of the medication; drug-interaction precautions; the possible side effects of stopping the medication; and how the treatment will be monitored was provided to: the child, if age appropriate and individuals in attendance or consulted in relation to this appointment.
- A review has been conducted of all medical information concerning the child which has been provided.
- The psychotropic medication, at the prescribed dosage, is appropriate for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication is expected to address.
- There is a need to prescribe psychotropic medication to the child based upon a diagnosed condition for which such medication is being prescribed.
- In the professional judgment of this prescribing physician, administering the above mentioned psychotropic medication(s) is in the best interest of the patient.

***If parental consent obtained:**

- I have discussed the information described above or attached regarding the prescribed psychotropic medication, the possible side effects, and potential medication interactions with the individual providing consent (biological parent, adoptive parent or legal guardian with documentation of Guardianship Order) and it is my clinical opinion that the person understands the information being provided. *NOTE: Relative, Non-Relative, Foster Parents and other licensed caregivers cannot provide consent for psychotropic medications.
- I have discussed possible other treatments with the person providing informed consent (biological parent, adoptive parent or legal guardian with documentation).
- I have informed the person providing this consent he/she may withdraw consent orally or in writing, before or during treatment, by notifying the prescribing physician, designee, or nurse on duty.

_____ _____
Physician's Signature Date

_____ _____
Print Name Telephone Number

_____ _____
License Number Address

☐ Child Psychiatrist ☐ Psychiatrist ☐ Pediatrician ☐ Other: _____

SECTION 5: PARENTAL CONSENT – ***Only parents, whose rights are still intact or individuals who have been granted legal or permanent guardianship by the court may consent to the administration of psychotropic medications.***

By signing this document, I am certifying that I am a parent or legal guardian of the above-named child, that my child's treatment plan has been explained to me by a doctor, and that I understand the nature, purpose, benefits, and possible risks of this treatment plan. I understand that I have the right to object to my child taking the recommended medications and the right to have my objection heard by a judge. I understand that I may revoke my consent to the recommended medications at any time, and the Department will then be required to obtain a court order in order for my child to continue the medication(s).

☐ I attended the appointment in person on _____ (date) and spoke directly with the prescribing physician on that date.

☐ I attended the appointment by phone on _____ (date) and spoke directly with the prescribing physician on that date.

☐ I spoke with the physician in person or by phone on _____ (date) and spoke directly with the physician on that date.

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Child's Name: _____ DOB: _____

Based on the information I have reviewed with the physician, I, _____
Printed Name of Parent or Legal Guardian

☐ **Consent** to the use of the psychotropic medication(s) listed on this form. ☐ **Do not** consent to the use of the psychotropic medication(s) listed on this form.

☐ Consent to the use of the following medications (specify): _____

_____ _____ _____
Parent or Legal Guardian's Signature | Relationship to Child | Date

CASE MANAGER CERTIFICATION: As the case manager I have reviewed the forgoing form and believe it to be complete. I understand the treatment plan for the child.

_____ _____ _____
Case Manager (print) | Case Manager (signature) | Date

****Additionally if a parent or legal guardian has not consented, the Case Manager must complete the following:**

☐ I, _____ (print Case Manager's name), certify that I have taken the following steps necessary to facilitate the inclusion of a parent or guardian, whose parental/guardian rights are intact, in the child's consultation with the prescribing physician:

	Date	Time		Date	Time
☐ Provided appointment details	.....	.....	☐ Attempted to reach parent(s)	.....	.....
☐ Attempted phone conference	.....	.....			.....
☐ Re-Scheduled Appointment	.....	.....			.....
☐ Offered transportation assistance	.....	.....			

☐ Other/Additional Comments: _____