Prescribing Psychotropic Medication
Children in Out-of-Home Care

MEDICAL REPORT

Child's Name: Sue Smith
Evaluating
Physician's Name: Dr. Mental Health
Address: 91 NW Pharmacy Rd

Florida, Florida 32601

Date/Time of Office Visit: 3/13/16
Phone #: 555-555-4444 Fax #: 555-555-4446
Please indicate if you are a:

☒ Child Psychiatrist ☐ General Psychiatrist

☐ Pediatrician ☐ Other: _____

Board Certified? ☒ Yes ☐ No

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 foster parents provide express and informed consent for a child to be prescribed a psychotropic medication.

Florida Statute 39.407 requires physicians who prescribe psychotropic medications to children in foster care 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 foster care system.

An electronic version of this form can be downloaded from
http://www.dcf.state.fl.us/DCFForms/Search/DCFFormSearch.aspx

Medical Report for

Children in Out-of-Home Care

(to be completed by the physician)

SECTION 1: CHILD'S INFORMATION

Name: Sue Smith Date of Birth: 2/25/2007

Height: _____ Weight: _____ Gender: F

SECTION 2: INFORMATION RECEIVED BY 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)

- ☒ Comprehensive Behavioral Health Assessment.
- ☒ Previous psychological evaluation.
- ☒ Current Health Physical Examination or recent well child exam.
- ☒ Referral Information including all medications currently prescribed, health status, health services and therapy currently receiving.
- ☒ Current school records, including assessments (e.g., Functional Behavioral Assessments, etc.)
- ☐ Other (list):

Persons Consulted: (Name, title/relationship to child, date of consultation)

Angel Johnson- Case Manager, 3/13/16

Jessica Smith- Mother, 3/13/16

Ron Smith-Father, 3/13/16

Does child's medical history include conditions that may indicate the presence of brain injury (for example, blows to head, fetal alcohol syndrome, loss of consciousness, head scars, fever above 104°)?

☐ Yes ☐ No ☐ Further assessment needed (see Section 4)

Other health conditions considered (list):

_____

Comments:

Child's Name: Sue Smith Date of Birth: 2/25/2007

SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS. ***Details should be provided for each separate diagnosis.*** *If necessary, continue on page 9 for additional diagnoses/medications. List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medications, including current medications that will be continued, for a complete profile. Please provide the Axis diagnosis(es) if known.*

Diagnosis # ___: ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder ☐ Depression

☐ Post Traumatic Stress Disorder ☐ Reactive Attachment Disorder ☐ Bipolar Disorder ☐ Mood Disorder

☐ Other (specify): _____

Medication recommended: Guanfacine

Starting dose: _____ Dosage Range: 0-4

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW ☒

This Medication is for ☐ Medical Condition ☒ Behavioral Health Condition

Comments regarding medication:

Diagnosis # 2 : ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder ☐ Depression

☐ Post Traumatic Stress Disorder ☐ Reactive Attachment Disorder ☒ Bipolar Disorder ☐ Mood Disorder

☐ Other (specify): _____

Medication recommended: Abilify

Starting dose: 10 mg Dosage Range: 0-15

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Lightheadedness, nausea, vomiting, stomach upset, tiredness, excessive saliva or drooling, weight gain, drowsiness.

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW ☐

This Medication is for ☐ Medical Condition ☐ Behavioral Health Condition

Comments regarding medication:

Child's Name: Sue Smith Date of Birth: 2/25/2007

SECTION 4: RECOMMENDED SERVICES, OTHER TREATMENTS. *Please include any psycho-social services, medical or psychiatric follow-ups, or treatments the child should receive in conjunction with this medication profile including a recommended schedule.*

Medication Monitoring Plan and Follow-up: Next Appointment: _____

Treatment monitoring frequency recommended:

☐ Weekly ☐ monthly ☐ 2months ☐ 3months ☐ 4 months ☐ 6 months ☐ annually

Follow-up visit frequency recommended:

☐ Weekly ☐ monthly ☐ 2months ☐ 3months ☐ 4 months ☐ 6 months ☐ annually

Lab Monitoring:

☐ CBC ☐ with differential ☐ without differential .....frequency: _____

☐ Comprehensive metabolic panel.....frequency: _____

☐ Basic metabolic panel .....frequency: _____

☐ Urinalysis .....frequency: _____

☐ Urine Toxicology Screen .....frequency: _____

☐ Pregnancy test ☐ Urine ☐ Blood

☐ TSH.....frequency: _____

☐ Lipid profile (HDL, LDL, Chol, Trig).....frequency: _____

☐ Lithium level ☐ Depakote/Depakene level ☐ Tegretol level

☐ Other laboratory tests not noted above:

Other Tests / Therapies / Services:

☐ Electrocardiogram (ECG/EKG) ☐ Neurological exam/assessment

☐ Other (specify):

☐ Therapy recommended:

☐ Psycho-social services recommended:

Child's Name: Sue Smith Date of Birth: 2/25/2007

SECTION 5: CERTIFICATION OF SIGNIFICANT HARM. *This section must be completed when it is likely that any delay in taking the prescribed medication would cause significant harm to the child.*

I, the physician, have reviewed all medical information concerning this child provided to me by DCF/CBC and/or the child's caregivers, and certify that a delay in providing the prescribed psychotropic is likely to cause significant harm to the child as noted below:

☒ **I find that it is likely that any delay in taking this medication would cause significant harm to this child.** 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. Delay in taking the psychotropic medication(s) will more likely than not harm the child.

Please provide detailed explanation of the nature and extent of harm the child will likely experience:
ADHD

☐ **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 3 business days.

SECTION 6: MEDICATION INFORMATION. *Section 39.407(3)(c)4., Florida Statutes (2009), requires that the Medical Report include information covering the recognized side effects, risks, contraindications, drug-interaction precautions, and possible effects of stopping medication for each medication. This information must be attached to this medical report. Medical reports without such information attached cannot be filed with the court.*

Please attach the appropriate information for all psychotropic medications listed in section 3 of this report.

☐ I have provided a copy of the attached medical information to the child and to the child's caregiver.

☐ I have also discussed this information with the child and with the child's caregiver.

SECTION 7: SUPPLEMENTAL INFORMATION. *Please describe below information on other treatment options. In addition please attach any supplemental information that might explain or support this medical report.*

1. Are there other treatment options available in lieu of administering the psychotropic medications recommended above? ☒ Yes ☐ No

   If yes, what are those alternatives?

2. Have these alternatives been tried? ☐ Yes ☒ No

   If yes, what was the response to the alternative treatments?

3. If the alternative treatments were not tried, explain why:

4. Other supplemental information:

Child's Name: Sue Smith Date of Birth: 2/25/2007

SECTION 8: EXPRESS AND INFORMED CONSENT BY PARENT OR GUARDIAN. *To be completed by parent or guardian in consultation with the physician.*

By signing this section I am certifying that I am a parent or guardian of the above-named child, and that the physician has explained to me each of the following (initial each):

_____ 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;

_____ what results are expected;

_____ the specific dosage range for the medication;

_____ alternative treatment options and the risks and benefits thereof;

_____ the approximate length of treatment;

_____ the potential effects of stopping treatment; and,

_____ how treatment will be monitored.

Further, by signing this section I am certifying the following (initial each):

_____ The physician has answered all of my questions about this medical report.

_____ I understand that I am not required to consent to this medical report. The Department may, after consultation with the prescribing physician, seek court authorization to provide the psychotropic medication to my child.

_____ I understand that any consent given for treatment in this medical report may be revoked orally or in writing before or during the treatment period and the Department will then be required to obtain a court order to continue the medication.

SIGN HERE IF YOU CONSENT TO THE TREATMENT:	**SIGN HERE IF YOU DO NOT CONSENT:**
_____ Signature of parent or guardian CONSENTING	_____ Signature of parent or guardian NOT CONSENTING
_____ Date	_____ Date

Jessica Smith
Print Name

Mother
Relationship to Child

Child's Name: Sue Smith Date of Birth: 2/25/2007

SECTION 9: SIGNATURE OF PHYSICIAN.

By signing this document, I am certifying that I have reviewed all medical information concerning the child which has been provided, and I am certifying that the psychotropic medication, at its prescribed dosage, is medically necessary for treating the child's diagnosed medical condition, as well as the behaviors and symptoms the medication, and its prescribed dosage, is expected to address.

☒ **I have discussed with the child's parent/legal guardian** 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.

☐ by phone ☒ in person

☒ **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 age/developmentally appropriate

Comments, especially reason for nonassent:

☐ I have not discussed this treatment with the parent/legal guardian and have not obtained express and informed consent for administration of this medication.

_____

Signature of prescribing physician

_____

Date Signed

Dr. Mental Health
Print Name

License: XX11114

Telephone Number: 555-555-4444

Emergency Contact Telephone Number: 911

Child's Name: _____ Date of Birth: _____

SECTION 3: DIAGNOSED CONDITIONS, SYMPTOMS, BEHAVIORS (continued from page 3).
Use this page only if it is necessary to continue from page 3 with additional diagnoses/medications. *List all diagnosed conditions, symptoms, and behaviors that support the need for the requested medications, including current medications that will be continued, for a complete profile. Please provide the Axis diagnosis(es) if known.*

Diagnosis # ___: ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder ☐ Depression
☐ Post Traumatic Stress Disorder ☐ Reactive Attachment Disorder ☐ Bipolar Disorder ☐ Mood Disorder
☐ Other (specify): _____

Medication recommended: _____

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW ☐

This Medication is for ☐ Medical Condition ☐ Behavioral Health Condition

Comments regarding medication:

Diagnosis # ___: ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder ☐ Depression
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☐ Other (specify): _____

Medication recommended: _____

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW ☐

This Medication is for ☐ Medical Condition ☐ Behavioral Health Condition

Comments regarding medication:

Child's Name: _____ Date of Birth: _____

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☐ Post Traumatic Stress Disorder ☐ Reactive Attachment Disorder ☐ Bipolar Disorder ☐ Mood Disorder
☐ Other (specify): _____

Medication recommended: _____

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW ☐

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Comments regarding medication:

Diagnosis # ___: ☐ ADHD/ADD ☐ Oppositional Defiant Disorder ☐ Adjustment Disorder ☐ Depression
☐ Post Traumatic Stress Disorder ☐ Reactive Attachment Disorder ☐ Bipolar Disorder ☐ Mood Disorder
☐ Other (specify): _____

Medication recommended: _____

Starting dose: _____ Dosage Range: _____

Expected length of medication treatment / Plan to reduce or eliminate the medication (Titration Plan):

_____

Side effects for caregiver to monitor:

Target symptoms/behaviors medication will address and expected results:

This Medication is NEW ☐

This Medication is for ☐ Medical Condition ☐ Behavioral Health Condition

Comments regarding medication:
