PSYCHOTROPIC MEDICATION INFORMED CONSENT

Michigan Department of Health and Human Services
For Children in Foster Care and/or Juvenile Justice

Section A – Identifying Information (completed by Child Welfare staff)

Child/Youth Name	Date of Birth	Medicaid ID #	MiSACWIS Person ID #
Legal Status	Current Placement Date	Placement Type	
Authorized Consenter(s)	Relationship to Child/Youth	Contact Phone	
Caseworker	Caseworker Phone	Agency	

Consents on File

Medication	Maximum Dose	Annual Review Due	Discontinued

Section B – Health Information (completed by medical provider or medical staff)

Physician Name	Phone	Appointment Date
Location of Appointment		
Mental Health Diagnoses		

Section C – Medication Recommendations (completed by physician or medical staff)

Medication Name	Recommended Dosage Range (maximum)	Check applicable box: New	Dose exceeds prior consent	Annual Review	No change
		☐	☐	☐	☐
		☐	☐	☐	☐
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I recommend the above listed medications for the treatment of this patient's symptoms. I have discussed the clinical diagnosis, reason for the medications, alternative treatments, possible side effects, and baseline/ongoing testing recommended with the party indicated as the authorized consenter for this patient.

Physician Signature	Date

Section D – Youth Attestation **Physician: If youth unable to attest, check here ☐ and initial: _____**

The physician talked with me about the above medications, and I have had the chance to ask questions.	
Youth Signature	Date

Section E – Consent (completed by consenting party listed in Section A)

My signature indicates I give consent for the use of medications listed in Section C identified as **NEW, DOSE EXCEEDS PRIOR CONSENT AND/OR ANNUAL REVIEW** and that the doctor discussed the:

- **DIAGNOSIS, TARGET SYMPTOMS, REASON FOR MEDICATIONS,**
- **OTHER ALTERNATIVE TREATMENTS,**
- **POSSIBLE SIDE EFFECTS,**
- **ANY TESTING NEEDED BEFORE OR WHILE ON THE MEDICATIONS.**

I hereby agree to the doctor's recommendations. This consent is voluntary, and I am aware that I can withdraw consent at any time, with written notification, during treatment. This consent expires after 1 year and a new consent is required if the treatment plan is continued.

Signature	Print Name	Date

☐ Discussed with physician in person ☐ Discussed with physician via telephone ☐ Physician provided written documentation

For Foster Care Only:

Questions: Call 844-764-PMOU (7668)

Caseworkers: **DO NOT UPLOAD IN MISACWIS.** Email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to: 517-763-0143.

Clinical personnel: Email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to: 517-763-0143.

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