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| 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 | | | |
|  | | | | |  | | | | |  | | | |
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| Caseworker | | | | | Caseworker Phone | | | | | Agency | | | |
|  | | | | |  | | | | |  | | | |
| **Consents on File** | | | | | | | | | | | | | |
| Medication | | | | | Maximum Dose | | | | Annual Review Due | | | Discontinued | |
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| **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](mailto:psychotropicmedicationinformedconsent@michigan.gov) or fax to: 517-763-0143.  Clinical personnel: Email (encrypted) to [psychotropicmedicationinformedconsent@michigan.gov](mailto:psychotropicmedicationinformedconsent@michigan.gov) or fax to: 517-763-0143. | | | | | | | | | | | | | |
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| For PMOU Office Use | |  | | | | | | |  | | | | |
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