

Medication Informed Consent Document
For Behavioral or Psychiatric Conditions
Clients < 18 years of age
A newly signed and dated form by all parties is required for changes in antipsychotic chemical entity or delivery system.

After completing the information below please fax to the CareSource PASSE Pharmacy Fax: 1-866-930-0019. For questions, call: 1-833-230-2100.

Client Information																										
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Prescriber Information																										
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PARENTAL/GUARDIAN CONSENT STATEMENT - I understand:																										
		With or without medicine, counseling is important to help change behavior.																								
		ledicine may help manage some symptoms.																								
H		What to expect without treatment, with counseling only, with medicine only, and with both counseling and medicine. can refuse the use of this or any other medicine at any time.																								
H					es cau	-				-		netim	nes the	se effe	ects m	nav be	e perm	naner	nt.							
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ш	 I was given an information sheet about the recommended medicine. The sheet tells about: FDA approval (if any) for using the medicine in children 																									
	Any safety concerns																									
	 How to stop taking the medicine What to do about missing a dose 																									
	How to keep track of the effects of the medicine																									
The effects and risks of this medicine may change over time. My child will need regular visits with the doctor to make sure it is safe to keep using the medicine.																										
PRESCRIBER SECTION																										
Patient's diagnosis (e.g. Bipolar II):																										
		ICD-1	10 Co	de fo	r diag	jnosi	s (e.g	. F31	.81):					DSM-	5 Co	de fo	r dia	gno	sis	(e.g.	 296.{	 39)				
Specific targeted symptoms to be addressed by antipsychotic medication:																										
	A comprehensive mental health or developmental/behavioral evaluation has been performed (CHECK ONE):																									
		In the	past	12+ n	nonth	S		In the	e past	12 m	nonth	3	[Cı	ırren	t refe	rral				No e	valua	ation	plar	nned	

Medication Informed Consent Document For Behavioral or Psychiatric Conditions Clients < 18 years of age A newly signed and dated form by all parties is required for changes in antipsychotic chemical entity or delivery system.

Prescriber signature (Required) Prescriber soriginal signature required; copied, stamped, or e-signature are not allowed. (By signature. the Prescriber confirms the above information is accurate and verifiable by patient records.) Prescriber soriginal signature required; copied, stamped, or e-signature are not allowed. (By signature. the Prescriber confirms the above information is accurate and verifiable by patient records.) PRESCRIBER LAST NAME: Parent/Guardian Signature Witness Signature	Patient a	nd/or fam	ily coun	seling or	behavior	al inte	erventi	ion?											
PRESCRIBER MUST SUBMIT THE FOLLOWING DOCUMENTATION: Progress/chart notes	Pas	t			Current			•		Refe	rred				No				
Progress/chart notes	Provider	comments	:																
Psychiatric evaluation				PRES	CRIBER MI	JST S	UBMIT	THE FO	LLOW	/ING D	OCUM	IENTA	ATION	l:					
Psycho-social history	=				_		-	•	•	nt)									
Medication Recommendation: Dose:							-			ont for	m								
Dose: Dosing Instructions (please write clearly): Medicines previously used and reason(s) discontinued: Other medicines continued or started: I have explained to the parent/guardian of patient the risks and benefits of this medication via: pHONE FACE-TO-FACE (Mark which method was used for education consultation) Prescriber Signature (Required) Date Prescriber's original signature required; copied, stamped, or e-signature are not allowed. (By signature, the Prescriber confirms the above information is accurate and verifiable by patient records.) RESCRIBER LAST NAME: PRESCRIBER FIRST NAME: PRESCRIBER FIRST NAME: PRESCRIBER FIRST NAME: Date Parent/Guardian of the patient named, I understand the risks and benefits of this medication. Relationship: Parent/Guardian Signature (Required) Date Date	FSycho-	SOCIAI IIISU	oi y			ompi	eleu III	ioiiiieu	COHS	5111 101	111								
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