Oregon Department of Human Services
CHILD WELFARE
Health and Wellness Services Program

Psychotropic Medication Authorization Form

Section A – Psychotropic medication recommendation: *(to be completed by licensed medical professional)*		☐ Residential/Facility
Date of Request: date Child's name:		Date of birth:
Assigned Sex: ☐ Male ☐ Female	Height:	Weight:
Prescribing licensed health care provider:		Telephone number:
Facility name:	Facility address:	

Clinical information: ***(to be completed by licensed medical professional)***

Concurrent medical diagnoses:
All mental health diagnoses:

All current psychotropic medication:

Medication/dosage/ administration schedule	Medication/dosage/ administration schedule	Medication/dosage/ administration schedule
Psychotropic medication to be discontinued:		

New medication and recommendation: ***(does not include dosage changes)***

Name of medication:	Dosage/route/frequency of administration:
Target symptoms:	Potential side effects:

Tests/procedures required before/during medication regimen: _____

Nonmedical approaches discussed: _____

Potential side effects reviewed with child: ☐ Yes ☐ No Medication Handout provided: ☐ Yes ☐ No

Explanation for New Medication Request: (Attach additional page, if needed)

Date of most recent MHA, if available:

Informed Consent:

I have had the opportunity to discuss the **reason for this prescribed psychotropic medication**, the **expected outcome(s)**, the approximate **length of treatment** and how the medication will be **monitored.** I have had the opportunity to discuss **alternative treatments** available. I have also had the opportunity to discuss the benefits and risks of this medication, including the possible **side effects**, the potential **medication interactions** and the potential **effects of stopping** the medication. I have had an opportunity to ask questions and have my questions answered.

Youth signature (if age 14 or older)	Date	Resource parent signature	Date

☐ Youth declined to sign

Signature of Health and Wellness Services Program Manager or designee is required prior to the administration of this medication. This form can be faxed to Health and Wellness at (503) 945-5635, sent via secure email to CW-Psychotropic.Med-Auth@odhsoha.oregon.gov, or given to the Caseworker.

Child's name: _____ Case/Person no: _____

Section B – Notification: ***(to be completed by caseworker)***

Legal parent(s) were notified of psychotropic medication(s): ☐ Yes ☐ No

Tribal Affiliation: ☐ Yes ☐ No Tribe notified: ☐ Yes ☐ No

Comments:

Section C – Child or young adult mental health assessment and placement information: ***(to be completed by caseworker)***

Required mental health assessment or update was completed within three months prior to the prescription for **more than one new psychotropic medication or any antipsychotic medication:** ☐ Yes ☐ No	Date of last mental health assessment:	Date of recent note:

Urgent medical need:

Date of urgent need episode:

Describe urgent medical need*: (include treatment facility licensed health care professional providing care)*:

Placement information:

Placement:

☐ Voluntary custody or placement ☐ Foster care ☐ Residential: _____

☐ Hospital: _____ ☐ Other: _____

Caseworker name:	Date completed:

Caseworker: Upon completion of this form fax to Health and Wellness Services at (503) 945-5635 or email CW-Psychotropic.Med-Auth@odhsoha.oregon.gov for processing.

Section D – Authorization for administration of psychotropic medications:
(to be completed by Health and Wellness Services Program Manager or designee)

☐ By signing below, I give authorization for _____ to receive the medication listed in section A, as recommended by his/her licensed health care provider.

☐ By signing below, I **do not** give authorization for _____ to receive the medication listed in section A, as recommended by his/her licensed health care provider. ***(If authorization is denied, reason must be provided below.)***

Reason authorization denied**:** _____

_____ _____

Signature of Health and Wellness Services Program Manager or designee Date

Print name:	Contact phone number: