

**PM FORM 3.15.3**

**Informed Consent for Children Under Five Years Old  
Psychotropic Medication Treatment (NARBHA Suggested Format)**

I have discussed the following information with my behavioral health medical practitioner (BHMP) for each medication listed below:

- The diagnosis and target symptoms for the medication recommended;
  - The possible benefits/intended outcome of treatment, and as applicable, all available procedures involved in the proposed treatment;
  - The possible risks and side effects;
  - The possible alternatives;
  - The possible results of not taking the recommended medication;
  - The possibility that my medication dose may need to be adjusted over time, in consultation with my BHMP;
  - My right to actively participate in my treatment by discussing medication concerns or questions with my BHMP; and
  - My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment is required in a Court Order or in a Special Treatment Plan).
  - I understand a **medication taper trial or consideration of taper is required every 6-8 months** until age 5. A Child Psychiatrist (CAP) will be consulted by my child's BHMP per DBHS guidelines.
- For persons under 18 years of age, the FDA status of the medication and the level of evidence supporting the recommended medication.

*I understand the medication information that has been provided to me. By signing below I agree to the use of this medication.*

<b>For Parent/Guardian:</b>			
<b>Medication &amp; Starting Dose</b>	<b>Target Symptoms to be addressed*</b>	<b>How Discussed**</b>	<b>PCP Coordination</b>
		<input type="checkbox"/> In Person <input type="checkbox"/> Telephone <input type="checkbox"/> Tele-Med <input type="checkbox"/> Previously	<input type="checkbox"/> Yes - Mail <input type="checkbox"/> Yes - Fax <input type="checkbox"/> Yes - Verbal
<b>Rationale for Medication Choice:</b> <input type="checkbox"/> parent/guardian preference <input type="checkbox"/> best or evidence-based practice <input type="checkbox"/> prior good response <input type="checkbox"/> diagnosis change <input type="checkbox"/> lack of full response <input type="checkbox"/> side effects <input type="checkbox"/> adverse effects <input type="checkbox"/> Other:			
<b>Targeted Outcomes</b> (such as able to attend preschool, less tantrums, etc.):			

\_\_\_\_\_  
Parent/Guardian Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

<b>For Non-Child Psychiatric BHMPs:</b>	<b>Child Psychiatrist Name &amp; Review Date</b>
Case was reviewed with Child Psychiatrist (CAP) prior to medication trial.	
Complete over-the-counter/medical/herbal/supplement/oxygen list was reviewed with CAP.	

- Monitoring plan as recommended by CAP: Frequency of Contact:  
 each week  
 every 2 weeks  
 monthly  
 Other:
- Labs  
 EKG  
 Referral to PCP  
 Taper review q 6-8 months  
 If lack of progress: q 3 months case review  
 Other:

\_\_\_\_\_  
Behavioral Health Medical Practitioner Printed Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\* Target Symptoms refer to specific symptoms associated with a diagnosis, such as tearfulness, hallucinations, insomnia. List the target symptoms rather than the underlying diagnosis.  
 \*\* "Previously" indicates the medication had been discussed in a previous setting or by another prescriber (hospital, another clinic, etc.) and you are verifying that the person continues to consent to treatment with this medication.  
 \*\*\* Ensure informed consent form with original patient signature is located in patient's file. If consent obtained by telephone or through tele-medicine, individual may initial and date at next face-to-face visit.

Child Name: \_\_\_\_\_  
 Child ID#: \_\_\_\_\_