SUBMIT | PRINT

FLORIDA MEDICAID
A Division of the Agency for Health Care Administration

INFORMED CONSENT FOR PSYCHOTHERAPEUTIC MEDICATION

[Children 0 to < 13 Years Old - *F.S. 394.492(3)*]

F.S. 409.912(51) The Agency may not pay for a psychotropic medication prescribed for a child in the Medicaid program without the express and informed consent of the child's parent or legal guardian. The physician shall document the consent in the child's medical record and provide the pharmacy with a signed attestation of this documentation with the prescription.

Recipient's Medicaid ID#

Date of Birth (MM/DD/YYYY) ___ / ___ / ____

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, AR, PA)

Prescriber Phone Number ___ - ____

Prescriber Fax Number ___ - ____

Psychotherapeutic Medication *[antipsychotics, antidepressants, anti-anxiety, mood stabilizers (anticonvulsants and ADHD medications not included)]*	**Dose Range**
1. _____	1. _____
2. _____	2. _____

Diagnoses:	Target Symptom(s):	Expected Outcome(s):
_____	_____	_____
_____	_____	_____

☐ I have discussed possible **other treatments** with the parent/guardian providing informed consent.

☐ I have discussed the **reason for treatment(s)**, the **expected outcome(s)**, the approximate **length of treatment**, and how the treatment will be **monitored** with the parent/guardian providing consent. I have also discussed the benefits and risks of this psychotherapeutic medication(s) including the possible **side effects**, the potential **medication interactions**, **contraindications** and the potential **effects of stopping** the medication with the parent/guardian providing consent. It is my clinical opinion that the person understands the information provided.

Signature of Prescribing Practitioner: _____ Date: _____

Parent/Legal Guardian (Print) :_____ Relationship to Recipient: _____

Phone Number: (Home): (____) _____ (Cell): (____) _____

☐ I consent to the use of the psychotherapeutic medication(s) listed above.

☐ I do not consent to the psychotherapeutic medication(s) listed above.

Comments:_____

_____

Signature of Parent/Legal Guardian: _____ Date: _____