

**Psychotropic Medication Request
Fax Cover Sheet**

Date: _____

Total Pages: _____

To: DCFS Consent Unit/UIC Research Team: Fax (312) 814-7015 (24-hour fax)

Contact Person

Contact Person Affiliation/Position

Contact Person Phone Number

Extension

Facility Name: (Hospital/Residential Center/DOC/JJ)

Fax Number

Facility Address

From: Agency Name

Agency Phone Number

Agency Fax: Number

Doctor

Doctor Phone Number

Doctor Fax: Number

Doctor Address

Region: Northern

Central

Southern

Cook

Notes/Comments:

Consent Hotline – 800-828-2179

After Hours (Child Intake and Recovery Unit) - 866-503-0184

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