CFS 431-A
Rev 12/2011

Illinois Department of Children & Family Services
PSYCHOTROPIC MEDICATION REQUEST FORM

Child's Name _____DCFS ID# (8digits) __ __ __ __ __ __ __ __ ❑ Male ❑ Female Date _____

Date of Birth _____**If 18 or older, include either consent from youth or continued guardianship court order** Ethnicity _____

Placement type: ❑ Foster Home ❑ Residential ❑ Hospital ❑ Family of Origin ❑ Shelter ❑ DOC ❑ Other_____

Facility or Agency Name _____Contact Person _____Phone _____Fax _____

Prescriber _____Specialty _____ Phone _____ Fax _____

Clinical Information

Psychiatric Diagnoses (include r/o): _____

_____

Medical Diagnoses: _____

Current Psychotropic Medications ❑No Current Meds

*include all current meds & dosages, meds on without consent and those being renewed

_____ ❑ to be discontinued
Medication Dosage Time Given

_____ ❑ to be discontinued
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Past trials/reason for discontinuation:_____

_____

_____

Other current medical medications, over the counter and supplements: _____

_____

Current weight _____ **Current height** _____
Date wt. and ht. last taken _____

Tests to be Monitored: Include Results and Date

❑ FBS _____ ❑HgAIC_____
❑ Lipids _____ ❑ Na _____
❑ K+_____ ❑ Mg++_____
❑ EKG_____ ❑ VPA level _____
❑ LiCO3 level _____ ❑ CBZ level _____
❑ LFT's _____ ❑ TFT's _____
❑ Kidney _____❑Other: _____

Will Monitor: Include Comments and Plan

❑ Adequate Growth _____
❑ Excessive Wt. Gain _____
❑ AIMS/DISCUS_____
❑ Other _____

Medication Request (all fields required for processing)

Type of request: ❑ New ❑ Increase ❑ Renewal (consent to expire) ❑ Resume (prior trial) ❑ New ward, current med ❑ One Time Order
❑ Emergency med (for acute sx's) ❑ On med or dosage w/o consent; Prescriber who started med _____Date started _____

Medication _____ Dosage _____Times Given _____ Range _____ Form_____ Duration _____
NOT TO EXCEED 180 DAYS

Symptoms/Behaviors for this medication (do not list diagnoses, acute = current; remitted = controlled on medication):

❑ This Medication is to treat acute symptoms; List Current Symptoms: _____

_____

❑ This Medication is for maintenance treatment; List Remitted Symptoms:_____

_____

Additional rationale for co-pharmacy, non-first-line medications, polypharmacy and other significant clinical information i.e. explanation of the treatment plan or history, alternative treatments (required for children <8), etiology of sleep disturbance. List all current adverse/side effects.

_____

_____

Side effects for all medications reviewed with child? ❑**YES** ❑**NO**

Does child object to the medication? ❑**YES** ❑**NO**

_____
IF YES, LIST MEDICATION AND EXPLAIN WHY CHILD OBJECTS

Form Completed by: ❑MD Office ❑ Facility Staff ❑ DCFS worker ❑ POS worker ❑ Agency ❑ Other_____

Name _____Phone _____ Fax _____

Number of pages: _____

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Instructions: Page 2 is for additional medication requests. **PAGE 1 MUST BE SENT** with any additional pages. To assure all pages are received, complete the following: INITIALS (of sender) ______PHONE NUMBER _____________ FAX NUMBER____________ DATE: ______________CHILDS NAME ____________________________DCFS ID __ __ __ __ __ __ __ __

Medication Request (all fields required for processing)

Type of request: ❑ **New** ❑ **Increase** ❑ **Renewal (consent to expire)** ❑ **Resume (prior trial)** ❑ **New ward, current med** ❑ **One Time Order**
❑ **Emergency med (for acute sx's)** ❑ **On med or dosage w/o consent; Prescriber who started med ______________Date started ___________**

Medication _________________________ Dosage __________Times Given _______________ Range ________ Form_______ Duration ________ NOT TO EXCEED 180 DAYS

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❑ **Emergency med (for acute sx's)** ❑ **On med or dosage w/o consent; Prescriber who started med ______________Date started ___________**

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Medication _________________________ Dosage __________Times Given _______________ Range ________ Form_______ Duration ________ NOT TO EXCEED 180 DAYS

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