CFS 431-B
Rev 5/2024

State of Illinois
Department of Children and Family Services

Psychotropic Medication Consent Form

Consent Date:

Child's Name: **Date of Birth:**
DCFS ID: **Placement Type:**
Child's Height: **Child's Weight:**
Legal Status: **Legal Date:**

Prescriber: **Prescriber Specialty:**
Fax/Email:
Date Psychotropic Medication Request Received:

DENIAL: DCFS Psychiatric Consultant, _____ has provided clinical consultation and deemed the requested medication as INAPPROPRIATE:

APPROVAL: DCFS Psychiatric Consultant, _____ has provided clinical consultation and deemed the requested medication as APPROPRIATE:

Note: Renewals for medication(s) with an expiration date of 90 days or greater can be requested as early as 45 days prior to expiration.

Medication/Dosage Requested:

Discontinued Medication:

Note: Continuing any medication in this section for longer than a 4-week taper is a violation of Rule 325. Please submit a request for any discontinued medication listed that you'd like to continue.

Current Medication:

Diagnosis:

Symptoms:

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Last, First: **DCFS ID:**
Consent Date:

If you have questions about the outcome of your consent request and/or would like to discuss it with the child psychiatrist who made the recommendation, please call the Clinical Services in Psychopharmacology mainline (312) 413-1233 for assistance.

Consent is _____ granted by the legal guardian, David L. Fox, via authorized agent, _____.

☐ **Approved** ☐ **Denied**

Date and Time of Consent and/or Denial _____

	David L. Fox	
DCFS Guardianship Administrator Signature	DCFS Guardianship Administrator	Date
DCFS Authorized Agency Signature	DCFS Authorized Agent	Date

Assigned Worker:_____

Supervisor:_____