Print Reset

Medication Informed Consent Document

For Behavioral or Psychiatric Conditions — Clients < 18 years of age

A newly signed and dated form by all parties is required for changes in antipsychotic chemical entity or delivery system.

After completing the information below please fax to the Arkansas Medicaid Pharmacy Program.

Fax completed form to 1-800-424-5851 For questions call 501-683-4120

BENEFICIARY INFORMATION

Medicaid ID: _____ Date of Birth: _____

Beneficiary Last Name: _____

Beneficiary First Name: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI: _____ DEA Number: _____

Prescriber Phone: _____ Prescriber Fax: _____

MEDICATION RECOMMENDATION

Drug Name: _____

Drug Strength: _____ Quantity: _____ Drug Form: _____

Dosing Instructions: _____

Medicines previously used: _____

Other medicines continued or started: _____

PRESCRIBER SECTION

Patient diagnosis (e.g., Bipolar II): _____

ICD-10 Code for diagnosis (e.g., F31.81): _____

DSM-5 Code for diagnosis (e.g., 296.89): _____

Specific targeted symptoms to be addressed by antipsychotic medication:

_____

A comprehensive mental health or developmental/behavioral evaluation has been performed (**Check one**):

☐ More than 12 months ☐ In the past 12 months

☐ Current referral ☐ No evaluation planned

Patient and/or family counseling or behavioral intervention?

☐ Past ☐ Current ☐ Referred ☐ No

Provider Comments:

Patient's Name: _____

PRESCRIBER MUST SUBMIT THE FOLLOWING DOCUMENTATION:

- ☐ Progress/chart notes
- ☐ Psychiatric evaluation
- ☐ Psycho-social history
- ☐ After-care plan (for inpatient)
- ☐ Labs every 6 months
- ☐ Completed informed consent form

PARENTAL/GUARDIAN CONSENT STATEMENT — I UNDERSTAND:

- ☐ With or without medicine, counseling is important to help change behavior.
- ☐ Medicine may help manage some symptoms.
- ☐ What to expect without treatment, with counseling only, with medicine only, and with both counseling and medicine.
- ☐ I can refuse the use of this or any other medicine at any time.
- ☐ Medicines may sometimes cause behavior or health problems. Sometimes these effects may be permanent.
- ☐ I was given an information sheet about the recommended medicine. The sheet tells about
  - FDA approval (if any) for using the medicine in children
  - Any safety concerns
  - How to stop taking the medicine
  - What to do about missing a dose
  - How to keep track of the effects of the medicine.
- ☐ The effects and risks of this medicine may change over time. My child will need regular visits with the doctor to make sure it is safe to keep using the medicine.

SIGNATURES

I have explained to the parent/guardian of patient the risks and benefits of this medication via:

☐ Phone ☐ Face-to-face (Select which method was used for education consultation.)

Prescriber Signature: _____ **Date:** _____

(**Prescriber's original signature required; copied, stamped, or e-signature are not allowed.**
By signature, the prescriber confirms the above information is accurate and verifiable in patient records.)

Prescriber Full Name (print /type): _____

As the parent/guardian of the patient named, I understand the risks and benefits of this medication as they have been explained to me and I consent to the use of the named medication.

Parent/Guardian Signature (required): _____

Date: _____ Relationship to Patient: _____

Parent/Guardian Last Name: _____

Parent/Guardian First Name: _____

Witness Signature: _____ Date: _____

Witness Last Name: _____

Witness First Name: _____