Physician's Request for Psychotropic Medication Authorization

To: The Honorable Patricia Bresee
Commissioner of the Juvenile Court
San Mateo County Superior Court

From: ______________________________, M.D. ______________________
(Phone Number)

Employed by______________________________

Medical Specialty______________________________

Board Eligibility/Certification______________________________

Re: Dependent Child______________________________ D.O.B.____________

Date of Evaluation______________________________

Location of Evaluation______________________________

CPS Social Worker______________________________ ______________________
(Phone Number)

Custodial Parent/Guardian______________________________

Address______________________________

____
(City) (State) (Zip)

Phone Number______________________________

1. Relevant Psychiatric History (specify current behaviors likely to be helped by psychotropic medication)____________
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2. DSM-IV Diagnosis (Axis I to V)______________________________
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3. Relevant medical and medication history (specify all medication child is **now** taking and possible interaction with the psychotropics you are recommending. Will psychotropics require reduction/discontinuation in current regimen?)________
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____
____

4. Psychotropics recommended:

   a) Name (trade and generic)____________________

      Category________________ Dose Range/Anticipated____________

      Treatment duration anticipated____________________

      Alternatives in same category (please name specific drug)____________

      ____

      Benefit anticipated________________________

   b) Name (trade and generic)____________________

      Category________________ Dose Range/Anticipated____________

      Treatment duration anticipated____________________

      Alternatives in same category (please specify)________________

      Benefit anticipated________________________

5. Either:

   (A) enclose San Mateo County MHS “Parent Medication Information Sheet”

   or

   (B) provide written narrative describing significant adverse reactions, warnings/contraindications, drug interactions, and anticipated time lag before full effect, for each medication you are recommending.

6. Dependent child’s response to medication recommendation (narrative or written statement) ____________

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   ____

   Signature:____________________

7. Custodial parent/guardian’s response to medication recommendation:________________

   ____

   Signature____________________

8. Current caregiver (if not same as #7) response to medication recommendation:________________

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   Signature:____________________

Request submitted on:________________

Signature of requesting physician:________________________