« SUPERIOR COURT OF CALIFORNIA, COUNTY OF LOS ANGELES »

Psychotropic Medication Authorization Form LOG #________________

For Court Use Only

THIS FORM MUST BE FAXED TO THE PROPER LOCATION BELOW TO OBTAIN COURT AUTHORIZATION PRIOR TO THE ADMINISTRATION OF PSYCHOTROPIC MEDICATION, ABSENT AN EMERGENCY.

DEPENDENCY: FAX: (562) 941-7205

DELINQUENCY: FAX: (323) 441-1110 OR (323) 441-1120

A. IDENTIFYING INFORMATION

Please include this form with discharge packet!

Child's Name (Last, First, MI)	D.O.B.	Sex	Ethnicity	Ct. Dept.	Court Case No.

Child's Current Placement Name and Address	Phone Fax	Plcmt. Contact Person

Placement Type: ☐ Relative ☐ Foster Home ☐ Group Home

Facility: ☐ B.J. Nidorf Juv. Hall ☐ Central Juv. Hall ☐ Los Padrinos Juv. Hall ☐ Probation Camp ☐ Dorothy Kirby Center ☐ State Hospital ☐ Developmental Center ☐ County Jail ☐ Other________________

☐ Acute Hospital Name: Address:	Phone Fax	Hosp. Contact Person

CSW/DPO: Name:________________________________ Region/Office: ______________ Phone: ________________

Name of Prescribing Physician (print) ____________________________________ License No. ______________

Specialty: ☐ Gen./Family Practice ☐ Pediatrics ☐ Neuro. ☐ Child/Adolesc.Psychiatry ☐ Gen.Psych. ☐ Other:______________

Address:

Office Phone: ____________________ Emergency Phone: _____________________ Fax: __________________

SECTIONS B & C ON PAGES 1 & 2 MUST BE PERSONALLY COMPLETED AND SIGNED BY THE PRESCRIBING PHYSICIAN.

B. CLINICAL INFORMATION

B1. Date child last seen by physician: ___________ Who brought child/what is relationship? ____________________________

B2. Information about child from: ☐ child- ☐ caregiver- ☐ teacher- ☐ records- ☐ other___________ Present illness duration: _______

B3. Diagnosis: (DSM IV Dx & Codes required) ____

____

B4. Current therapeutic services other than medication (specify type, frequency, location): ____________________

____

____

B5. Last Physical Exam (Minor must have had physical exam during the 12 months prior to starting psychotropic medication and then yearly.)

Date of PE: __________ Location of PE records: ____

Current Height: __________ Weight: ___________ Date Measured: ______________

Significant Medical Problems or Lab Test, BP or Pulse Abnormalities: ☐ No ☐ Yes

Non-psychotropic prescribed medications taken regularly: ☐ No ☐ Yes

} If Yes, describe below or attach information.

B6. Indicate relevant **laboratory tests** performed or ordered. ☐ No lab work done/ordered

☐ CBC ☐ UA ☐ Liver Function ☐ Thyroid Function ☐ Kidney Function ☐ Glucose ☐ Lipid Panel ☐ Electrolytes ☐ EKG

☐ Medication Blood Level (specify): ______________________ ☐ Other: ______________________________

B7. Current Psychotropic medication request is: ☐ **Continuation of Rx Only** ☐ **Non-emergency** ☐ **Emergency**

Nature and circumstances of emergency must be specified here to allow for temporary administration pending judicial order:

(Administration of Continued medication or Emergency medication may proceed immediately upon submission of form.)

____

____

Child's Name (Last, First, MI) ______________________ LOG # ______________

C. MEDICATIONS (List all psychotropic medications now being taken or to be taken when authorized or being discontinued.)

Mark them N ew-C ontinued-D iscontinued (**with respect to the child not the prescribing physician**) (Use additional sheet if needed.)

Indicate if **cross titrating medications.** If use of a medication is to be **short-term (less than 6 months)**, specify time frame.

C1. NAME OF MEDICATION(S) AND TARGET SYMPTOMS FOR EACH	N or C or D	ADMINISTRATION SCHEDULE • Indicate Initial and Target Schedules for New Rx • Indicate Current Schedule for Continued Rx • Indicate mg/dose and # of doses/day • If PRN, specify conditions & parameters of use	MAXIMUM TOTAL DOSE/DAY
Med: Targets:			
Med: Targets:			
Med: Targets:			
Med: Targets:			
Med: Targets:			
Med: Targets:			

C2. Indicate **response** to ongoing Rx treatment and reasons for any Rx changes (with respect to target symptoms &/or adverse effects):

____

____

____

C3. Prior medications: ____

C4. **(Completion of C4 a. or b. is required.)** **(Complete C5 and/or C6 if they are applicable.)**

a. ☐ Child has been informed of the proposed medication treatment, anticipated benefits and potential adverse effects.

Child is ☐ agreeable to ☐ opposed to the proposed treatment. (Child's own written statement may be attached.)

b. ☐ Child has not been informed because the child is too young and/or lacks the capacity to understand the treatment or provide a response.

C5. ☐ Child's current Foster Parent or Relative Caretaker has been informed of the proposed medication treatment, anticipated benefits and potential adverse effects.

Foster parent or Relative Caretaker is ☐ agreeable to ☐ opposed to the proposed treatment (Use additional sheet if needed.)

C6. ☐ Child's Parent or Legal Guardian (circle one) will not or cannot consent to the proposed treatment.

Additional explanation (Use additional sheet if needed.): ____

____

I hereby declare that all the foregoing is true to the best of my knowledge.	**Prescribing Physician's Signature**	Date

Child's Name (Last, First, MI) ________________________________ **LOG #** ____________________

D. NOTICE

- **Parent/Guardian Notice sent on:** ____________________ (Date) **Notifying Agency:** ☐ **Probation** ☐ **DCFS**

  By: ______________________________ (Print Name) ______________________________ (Sign)

  If not sent, reason:____

- **Child's Attorney Notice sent by Court on:** ____________________ (Date)

  By: ______________________________ (Print Name) ______________________________ (Sign)

  If not sent, reason:____

E. JCMHS REVIEW

☐ **This form has been reviewed by staff of Juvenile Court Mental Health Services. This review is intended to give the court general information regarding the appropriateness of the psychotropic medication treatment for which authorization is requested given the clinical information indicated on the form (age, diagnosis, symptoms, etc.).**

See attached JCMHS review page for further information.

F. COURT ORDER (to be completed by the court)

Court having read and considered the above request:

- ☐ **The matter is set for a hearing within five court days on (date):** ____________ **at (time):** _____ **in department:** ____
- **The application for authorization to administer psychotropic medication is**
  - a) ☐ **Granted as requested**
  - b) ☐ **Denied (specify reason for denial):**
  - c) ☐ **Granted with the following modifications or conditions (specify):**

- **This order for authorization is effective until terminated or modified by court order or until 180 days from this order, whichever is earlier. If the prescribing physician named above is no longer treating the child, the authorization may extend to physicians who subsequently treat the child. Except in an emergency situation, an increase in the dosage beyond the approved maximum daily dosage or a change in or the addition of other medications requires the treating physician to submit a new application. A change in the child's placement does not require a new order for psychotropic medication, and this authorization, if it is still in effect, must accompany the child if placement is changed.**

- **Notice Requirements**
  - a) ☐ **The notice requirements have been met.**
  - b) ☐ **The notice requirements have NOT been met. Proper notice was not given to:** ____________________________

Date: ____________ ______________________________ (Print Name) ______________________________ (Sign)

Judicial Officer of the Juvenile Court