Medication Informed Consent Document
For Behavioral or Psychiatric Conditions

After completing the information below please fax to the Arkansas Medicaid Pharmacy Program. Fax: 1-800-424-7976. For questions call: 1-800-424-7895.

Beneficiary Information

LAST NAME: | **FIRST NAME:**

MEDICAID ID NUMBER: | **DATE OF BIRTH:** – –

Prescriber Information

LAST NAME: | **FIRST NAME:**

NPI NUMBER: | **DEA NUMBER:**

PHONE NUMBER: – – | **FAX NUMBER:** – –

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.

PROVIDER SECTION

☐ **Targeted symptoms** (signs and symptoms identified by the provider for treatment with antipsychotic medication)

☐ **A comprehensive mental health or developmental/behavioral evaluation has been performed (CHECK ONE):**

☐ More than 12 months ago ☐ In the past 12 months ☐ Current referral ☐ No evaluation planned

☐ **Patient and/or family counseling or behavioral intervention?**

☐ Past ☐ Current ☐ Referred ☐ No

Provider comments:

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☐ **Medication Recommendation** _____

Dose _____ Dosing Instructions (please write clearly). A newly signed and dated form by all parties is required for changes in antipsychotic chemical entity or delivery system.

Medicines previously used: _____

Other medicines continued or started: _____

I have explained to the parent/guardian of patient the risks and benefits of this medication via: ☐ **PHONE** ☐ **FACE-TO-FACE**

(Mark which method was used for education consultation)

_____ ☐☐ - ☐☐ - ☐☐☐☐

Prescriber Signature (Required) ***Date***

Prescriber's original signature required; copied, stamped, or e-signature are not allowed.

(By signature, the Physician confirms the above information is accurate and verifiable by patient records.)

PRESCRIBER LAST NAME: **PRESCRIBER FIRST NAME:**

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. ***Relationship:*** _____

_____ ☐☐ - ☐☐ - ☐☐☐☐

Parent/Guardian Signature (Required) ***Date***

PARENT/GUARDIAN LAST NAME: **PARENT/GUARDIAN FIRST NAME:**

_____ ☐☐ - ☐☐ - ☐☐☐☐

Witness Signature ***Date***

WITNESS LAST NAME: **WITNESS FIRST NAME:**