DHS-1643, PSYCHOTROPIC MEDICATION INFORMED CONSENT

Michigan Department of Health and Human Services (MDHHS)
For Children in Foster Care and/or Juvenile Justice
(Revised 1-26)

FC-PMOU Use Only

SECTION 1 – IDENTIFYING INFORMATION (Completed by Child Welfare staff)

Child/Youth Name		Date of Birth
Medicaid ID Number	MiSACWIS Person ID Number	Legal Status
Authorized Consenter(s)	Relationship to Child/Youth	Case Manager Name

SECTION 2 – HEALTH INFORMATION (Completed by medical provider or medical staff)

Physician Name	Phone Number	Appointment Date

Name of Medical Practice/Facility

Diagnoses Linked to Psychotropic Medication Use in Section 3.

SECTION 3 – MEDICATION RECOMMENDATIONS (Completed by physician or medical staff)

Medication Name	Dose Range (Min) (Max)	Discontinued Date	PRN Only*	Lab Monitoring Recommended
	I		☐	☐
	I		☐	☐
	I		☐	☐
	I		☐	☐
	I		☐	☐
	I		☐	☐
	I		☐	☐
	I		☐	☐
	I		☐	☐

I recommend the above listed medications for the treatment of this patient's symptoms. I discussed clinical diagnosis, reason for the medications, alternative treatments, possible side effects, and baseline/ongoing testing recommended with the party indicated as the authorized consenter for this patient.

Physician Signature	Date

SECTION 4 – CONSENT (Completed by consenting party listed in SECTION 1)

Consenter Signature	Printed Name	Date

My signature indicates I give consent for the use of medications listed in SECTION 3 identified as **Medication Name, Dose Range (Min) (Max), Discontinued Date, *Pro re nata (PRN) or a medication administered "as needed," Lab Monitoring Recommended** and that the doctor discussed the:

- **Diagnosis, target symptoms, reason for medications,**
- **Other alternative treatments,**
- **Possible side effects,**
- **Any testing needed before or while on the medications.**

I hereby agree to the doctor's recommendations. This consent is voluntary, and I am aware that I can withdraw consent at any time, with written notification, during treatment. This consent expires after 1 year and a new consent is required if the treatment plan is continued.

SECTION 5 – INSTRUCTIONS

Questions: Call 844-764-PMOU (7668)

Case manager and child welfare staff: **DO NOT UPLOAD IN MISACWIS**.
Email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to 517-763-0143.
Include any court orders authorizing the use of psychotropic medications or alternative consenter(s) with this DHS-1643.

Clinical personnel: Send to requesting child welfare staff. If requested by the FC-PMOU, email (encrypted) to psychotropicmedicationinformedconsent@michigan.gov or fax to 517-763-0143.

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