# ATTACHMENT 3

# JV-220(A) Prescribing Physician's Statement—Attachment

Case Number:

This form must be completed and signed by the prescribing physician. Read JV-219-INFO, *Information About Psychotropic Medication Forms,* for more information about the required forms and the application process.

1. Information about the child *(name)*: _____

   Date of birth: _____ Current height: _____ Current weight: _____

   Gender: _____ Ethnicity: _____

2. Type of request:

   a. ☐ An initial request to administer psychotropic medication to this child

   b. ☐ A request to continue psychotropic medication the child is currently taking

3. ☐ This application is made during an emergency situation. The emergency circumstances requiring the temporary administration of psychotropic medication pending the court's decision on this application are:

   _____

   _____

   _____

4. Prescribing physician:

   a. Name: _____ License number: _____

   b. Address: _____

   c. Phone numbers: _____

   d. Medical specialty of prescribing physician:

   ☐ Child/adolescent psychiatry ☐ General psychiatry ☐ Family practice/GP ☐ Pediatrics

   ☐ Other *(specify)*: _____

5. This request is based on a face-to-face clinical evaluation of the child by:

   a. ☐ the prescribing physician on *(date)*: _____

   b. ☐ other *(provide name, professional status, and date of evaluation)*: _____

   _____

6. Information about child provided to the prescribing physician by *(check all that apply)*:

   ☐ child ☐ caregiver ☐ teacher ☐ social worker ☐ probation officer ☐ parent

   ☐ records *(specify)*: _____

   ☐ other *(specify)*: _____

7. Describe the child's symptoms, including duration as well as the child's response to any current psychotropic medication. If the child is not currently taking psychotropic medication, describe treatment alternatives to the proposed administration of psychotropic medication that have been tried with the child in the last six months. If no alternatives have been tried, explain the reasons for not doing so.

   _____

   _____

   _____

   _____

   _____

   _____

Case Number:

Child's name: _____

(8) Diagnoses from *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) (provide full Axis I and Axis II diagnoses; inclusion of numeric codes is optional):*

_____

_____

_____

(9) Therapeutic services, other than medication, in which the child will participate during the next six months *(check all that apply; include frequency for group therapy and individual therapy):*

a. ☐ Group therapy: _____ b. ☐ Individual therapy: _____

c. ☐ Milieu therapy *(explain):* _____

d. ☐ Other modality *(explain):* _____

(10) a. Relevant medical history *(describe, specifying significant medical conditions, all current nonpsychotropic medications, date of last physical examination, and any recent abnormal laboratory results):*

_____

_____

_____

_____

_____

b. Relevant laboratory tests performed or ordered *(optional information; provide if required by local court rule):*

☐ kidney function ☐ liver function ☐ thyroid function ☐ UA ☐ glucose ☐ lipid panel

☐ CBC ☐ EKG ☐ pregnancy ☐ medication blood levels *(specify):* _____

☐ other *(specify):* _____

(11) **Mandatory Information Attached:** Significant side effects, warnings/contraindications, drug interactions (including those with continuing psychotropic medication and all nonpsychotropic medication currently taken by the child), and withdrawal symptoms for each recommended medication are included in the attached material.

(12) a. ☐ The child was told in an age–appropriate manner about the recommended medications, the anticipated benefits, the possible side effects and that a request to the court for permission to begin and/or continue the medication will be made and that he or she may oppose the request. The child's response was

☐ agreeable ☐ other *(explain):* _____

b. ☐ The child has not been informed of this request, the recommended medications, their anticipated benefits, and their possible adverse reactions because:

(1) ☐ the child is too young.

(2) ☐ the child lacks the capacity to provide a response *(explain):* _____

_____

(3) ☐ other *(explain):* _____

(13) The child's present caregiver was informed of this request, the recommended medications, the anticipated benefits, and the possible adverse reactions. The caregiver's response was ☐ agreeable ☐ other *(explain):*

_____

(14) Additional information regarding medication treatment plan: _____

_____

_____

Case Number:

Child's name: _____

**15** List all psychotropic medications currently administered that you propose to continue and all psychotropic medications you propose to begin administering. Mark each psychotropic medication as New (N) or Continuing (C). Administration schedule is optional information; provide if required by local court rule.

| *Medication name (generic or brand) and symptoms targeted by each medication's anticipated benefit to child* | *C or N* | *Maximum total mg/day* | *Treatment duration** | *Administration schedule (optional)*<br>• Initial and target schedule for new medication<br>• Current schedule for continuing medication<br>• Provide mg/dose and # of doses/day<br>• If PRN, provide conditions and parameters for use |
|---|---|---|---|---|
| Med:<br>Targets: | | | | |
| Med:<br>Targets: | | | | |
| Med:<br>Targets: | | | | |
| Med:<br>Targets: | | | | |
| Med:<br>Targets: | | | | |

**Authorization to administer the medication is limited to this time frame or six months from the date the order is issued, whichever occurs first.*

**16** List all psychotropic medications currently administered that will be stopped if this application is granted.

| *Medication name (generic or brand)* | *Reason for stopping* |
|---|---|
| | |
| | |
| | |
| | |

**17** List the psychotropic medications that you know were taken by the child in the past and the reason or reasons these were stopped if the reasons are known to you.

| *Medication name (generic or brand)* | *Reason for stopping* |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Date: _____

_____
*Type or print name of prescribing physician*

_____
*Signature of prescribing physician*