Lucas County Children Services

Psychotropic Medication Authorization

Dear Doctor,

Child: ____ **DOB:** _____________

is in the custody of LCCS. It is the policy of LCCS to monitor all children receiving psychotropic medication. Please discuss the medication, its desired effect and possible side effects with the child and his/her caregiver. Please see this child on a regular basis. We will send you a request for a progress twice yearly.

Utilize this form as notification of medication initiation or changes. This form must be accompanied by office notes indicating the need for the medication.

Physician:
Complete this portion which must be returned to LCCS along with a copy of a current mental health evaluation. After receiving your information we will obtain authorization from the LCCS Executive Director.

Diagnosis: ____

Medication: __________________________ Dosage ______________ Times ____________

Medication: __________________________ Dosage ______________ Times ____________

Medication: __________________________ Dosage ______________ Times ____________

Desired effect: ____

Possible side effects: ____

Plan for follow up office visits for medication monitoring:

____

☐ Yes ☐ No Have you discussed the medication, its desired effects with the child (if age appropriate) and the caretaker?

Miscellaneous concerns or comments

____

MD Signature: _____________________________________ Date: _______________________

➲ **If this is the initial prescription appointment** and the child is to start on medication, the caretaker may take the prescription slip home. This prescription should not be filled until the LCCS clinic nurse or caseworker notifies the caretaker that medication has been authorized by the LCCS Executive Director.

➲ **If the child came into LCCS custody on psychotropic medication**, the child should continue on medication without interruption.

AUTHORIZATION

Date Signed: ______________________ Signature of LCCS Executive Director ____

If you have any questions or concerns please contact: LCCS Health Services, 705 Adams St., Toledo, OH 43604

Clinic FAX: 419-327-3358 Clinic Phones: 419-213-3340, 419-213-3343, 419-213-3284, 419-213-3365