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 caretaker. Please see this child on a regular basis. We will send you a request for a progress report twice per year.

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, LCCS will review and notify you if the medication is authorized.

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 and possible side effects with the child (if age appropriate) and the caretaker?

Miscellaneous concerns or comments: _____

MD Signature: _____ Date: _____

Authorization

Authorized Signature: _____ Date: _____

If you have any questions or concerns, please contact: LCCS Health Services, 301 Adams St., Toledo, OH 43604; Fax: 419-327-3358; Phone: 419-213-3340, 419-213-3343, 419-213-3365, or 419-213-3284

☐Authorize	
☐Defer	Reason:
☐Act in Accordance with:	Reason: