



**PSYCHOTROPIC MEDICATION  
TREATMENT PLAN REVIEW**

Pre-Psychotropic Medication Consent  
Review for Children Birth through 5 Years Old

Prescribing Practitioner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Section 1 is to be completed by the Child Case Manager / Child Welfare Worker**

**Section 1: Demographic Information**

Child's Name: \_\_\_\_\_ Date of Office Visit: \_\_\_\_\_

Address: \_\_\_\_\_ Child's Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
DCF District/Region: \_\_\_\_\_

Case Manager/Child Welfare Staff: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Case Manager Supervisor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

DCF Contracted Agency: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Obtaining Informed Consent was attempted from the parent/guardian:  YES  NO Date: \_\_\_\_\_

Person Consulted: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Please explain: \_\_\_\_\_

**Sections 2 through 5 are to be completed by the Prescribing Practitioner**

**Section 2: Diagnosis / Disorder / Behavioral Hypothesis**

- Depression       Oppositional Defiant Disorder       ADHD       Anxiety Disorder
- Conduct Disorder       Post Traumatic Stress Disorder       Substance Abuse       Mental Retardation
- Substance Abuse       Reactive Attachment Disorder       Bipolar Disorder       Autism/Asperger's
- Psychosis       Learning Communication/Speech       Other (specify): \_\_\_\_\_
- Rule Out: \_\_\_\_\_

**Section 3: Psychotropic Medication Planned**

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Dosage Range: \_\_\_\_\_  
(age appropriate)

Titration Plan: \_\_\_\_\_

Start Date: \_\_\_\_\_ to address the following target symptoms: \_\_\_\_\_

Define treatment success/failure: \_\_\_\_\_

Define monitoring plan (include frequency of planned monitoring: \_\_\_\_\_

If the above medication fails to meet the identified goal, the following medication in the same drug class will be tried:

Medication: \_\_\_\_\_ Dose: \_\_\_\_\_ Dosage Range: \_\_\_\_\_  
(age appropriate)

Titration Plan: \_\_\_\_\_



FLORIDA DEPARTMENT OF  
**CHILDREN  
& FAMILIES**  
  
PSYCHOTROPIC MEDICATION TREATMENT PLAN REVIEW  
Pre Psychotropic Medication Consent  
for Children Birth through 5 Years Old

Prescribing Practitioner's Name: \_\_\_\_\_  
Child's Name: \_\_\_\_\_  
Date/time of Office Visit: \_\_\_\_\_  
Date/time faxed to UF: \_\_\_\_\_

Additional Supporting Information: \_\_\_\_\_  
\_\_\_\_\_

**Section 4: Other Planned Treatments / Therapies / Evaluations / Tests: (Please list provider(s))**

\_\_\_\_\_  
\_\_\_\_\_

**Section 5: Medical Problems and Other Medications (including over the counter medications)**

\_\_\_\_\_  
\_\_\_\_\_

Signature of Prescribing Practitioner / Date

**Section 6 is to be completed by the UF Consultant Child Psychiatrist**

**Section 6: Psychotropic Medication Treatment Plan Review**

Phone consultation between: \_\_\_\_\_ and \_\_\_\_\_  
Prescribing Practitioner/Title UF Child Psychiatrist

Date/Time: \_\_\_\_\_

UF Child Psychiatrist Review (check one)

- I concur with the treatment plan listed by the attending prescribing practitioner on page 1.
- I concur with the treatment plan on page 1 with the following modifications that I have discussed with the prescribing practitioner: \_\_\_\_\_

- I need the following information to provide an opinion regarding this child's psychotropic medication treatment plan: \_\_\_\_\_

- I do not concur with the identified treatment plan and recommend an alternative plan: \_\_\_\_\_

University of Florida, School of Medicine, Department of Psychiatry  
MedConsult: Phone number: 866-453-2266  
MedConsult: Fax number: 352-846-1455

\_\_\_\_\_  
**UF Child Psychiatrist Signature / Date**

Date and time faxed to the child's case manager and prescribing practitioner: \_\_\_\_\_