JV-220(B) Physician's Request to Continue Medication—Attachment

Case Number:

This form must be completed and signed by the prescribing physician. Read form JV-217-INFO, *Guide to 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 Fill out this form only if both boxes below are checked. If you cannot check both boxes, fill out form JV-220(A).

a. ☐ This is a request to continue the same psychotropic medication and maximum dosage that the child is currently taking.

b. ☐ This is the same prescribing physician who completed the most recent form JV-220(A).

3 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):* _____

4 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):* _____

_____

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

☐ Child ☐ Caregiver ☐ Teacher ☐ Social worker ☐ Probation officer ☐ Parent

☐ Public health nurse ☐ Tribe

☐ Records *(specify):* _____

☐ Other *(specify):* _____

6 Provide to the court your assessment of the child's overall mental health.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Child's name: _____

Case Number:

7 a. Describe the child's response to any current psychotropic medication.

b. Describe the symptoms not alleviated or ameliorated by other current or past treatment efforts.

8 a. Have nonpharmacological treatment alternatives to the proposed medications been tried in the last six months?

☐ Yes ☐ No ☐ I don't know.

b. If yes, describe the treatment and the child's response. If no, explain why not.

9 Diagnoses from *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5):*

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

Child's name: _____

Case Number:

11 a. ☐ All essential laboratory tests were performed.

b. ☐ All essential laboratory tests were not performed *(explain what laboratory tests were not done and why).*

_____

_____

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 ☐ Not agreeable

Briefly describe child's response: _____

_____

_____

_____

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

_____

(2) ☐ Other *(explain):* _____

13 a. **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.

b. ☐ The caregiver was informed of the mandatory information, which is attached.

c. ☐ The caregiver's response was ☐ agreeable ☐ other *(explain):*

_____

_____

_____

_____

_____

_____

_____

14 Additional information regarding medication treatment plan and follow-up: _____

_____

_____

_____

_____

_____

_____

_____

Child's name: _____

Case Number:

15 Therapeutic services, other than medication, in which the child is enrolled in or is recommended to participate during the next six months *(check all that apply; include frequency for therapy on blank line):*

a. ☐ Group therapy: _____ b. ☐ Individual therapy: _____
c. ☐ Milieu therapy *(explain):* _____
d. ☐ Therapeutic Behavioral Services (TBS): _____
e. ☐ Therapy for children on the autism spectrum: _____
f. ☐ Art therapy: _____ g. ☐ Cognitive behavioral therapy (CBT): _____
h. ☐ Wraparound services: _____
i. ☐ American Indian/Alaska Native healing and cultural traditions: _____
j. ☐ Speech therapy: _____
k. ☐ In Home Behavioral Services (IHBS): _____
l. ☐ Other modality *(explain):* _____

16 List all psychotropic medications currently administered that you propose to continue.

Medication name (generic/brand) and symptoms targeted by each medication's anticipated benefit to child	*Maximum total mg/day*	*Treatment duration* 6-month maximum*	*Administration schedule* • Initial and target schedule for new medication • Current schedule for continuing medication • Provide mg/dose and # of doses/day • If PRN, provide conditions and parameters for use
Med: Class: Targets:			
Med: Class: Targets:			
Med: Class: Targets:			
Med: Class: 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.*

17 Other information about the prescribed medication that you want the court to know (e.g., reasons for prescribing more than one medication in a class, prescribing outside the approved range, or prescribing medication not approved for a child of this age):

_____
_____
_____
_____
_____
_____

Date:

_____ _____

Type or print name of prescribing physician *Signature of prescribing physician*

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