City and County of San Francisco
Department of Public Health
San Francisco Health Network
BEHAVIORAL HEALTH SERVICES

Name:
Client ID:
Program Code:

Informed Consent for Psychiatric Medication(s) - CYF

THE PURPOSE OF THIS FORM IS TO DOCUMENT THAT YOU AND THE PROVIDER ORDERING YOUR MEDICATIONS (YOUR PRESCRIBER) HAVE DISCUSSED YOUR CHILD'S MEDICATION(S) TO YOUR SATISFACTION.

Your prescriber has ordered the following medication(s) for your child. You are entitled to know the following information before deciding whether your child takes the medication(s):

1. What condition or diagnoses your child has that these medications are prescribed to address
2. Which symptoms the medication(s) should reduce and how likely the medication(s) will work
3. What are the chances of getting better without taking the medication(s)
4. Reasonable options or alternatives to taking the medication(s)
5. Name, type (or class) of medication, dosage, dosage range, frequency of administration, route of administration and duration of each prescribed medication
6. Common side effects of the medication(s), including possible additional side effects which may occur beyond three months (long term), and may be potentially irreversible
7. If antipsychotic medications are prescribed, notice that antipsychotic medications may cause additional side effects for some persons, including persistent involuntary movements which are potentially irreversible, and may continue after the antipsychotic medication has been stopped
8. Any special instructions you should know about taking the medication(s)

Medication	Route		Dosage Range
	☐ Oral	☐ Inject	
	☐ Oral	☐ Inject	
	☐ Oral	☐ Inject	
	☐ Oral	☐ Inject	
	☐ Oral	☐ Inject	

- By signing this form, you indicate the above medication(s) have been explained to your satisfaction in your preferred language, and understand that you can ask questions about your child's medication(s) at any time.
- By signing this form, you consent to this treatment for your child.
- After signing, you can still refuse any dose or withdraw your agreement completely at any time notifying your prescriber either verbally or in writing.
- You will receive a copy of this consent form.
- You have received information about the medications in your preferred language by means of:
  ☐ Oral explanation ☐ Printed material ☐ Other_____
- This consent form remains valid for a period of one year from date of the prescriber's signature.

	Date
Parent/Guardian Signature:	
Prescriber Name (print):	
Prescriber Signature with type of professional degree, and licensure or job title:	
Client Signature (optional):	
Witness (required if client unable or signs with a mark):	

If unable to obtain a signature, please check the box below and document the reason:

☐ The parent/guardian verbally consents to the recommended medication(s), but is unable or refuses to sign because:

Continued attempts to obtain signature: Initials_____Date_____Initials_____Date_____

Procedure for Informed Consent for Psychiatric Medication(s) Consent Form – CYF (MM05-CYF)

Purpose:

1. To serve as a record of the parent/guardian's consent for psychiatric medication(s) as part of their child's treatment regimen
2. To document that the parent/guardian has been provided information about the medication(s) being prescribed
3. As applicable, to document the client's receipt of medication information and consent (optional)

Responsibilities for Documentation:

1. Refer to policy and procedures in 3.5-04 "BHS Psychiatric Medication Consent in Ambulatory Care"
2. In situations when a non-electronic form is used such for some field services, complete this form and document the consent in the electronic Avatar Medication Consent form.
3. For non-urgent medication consents for San Francisco Human Services Agency (HSA) Court Dependent children/adolescents, the JV220 and JV220A request for medications to the court must be completed and fully executed (signed by the court) before medications(s) are prescribed.
4. The prescriber has the responsibility for filling out the form once the parent/guardian has received information in their preferred language about the medication(s).
5. The consent process must be renewed at least annually.
6. A new consent form must be executed when any new medication(s) are started, or if there are any changes in route or dosage range.
7. A copy of the consent form shall be given to the parent/guardian.
8. The completed form must be filed permanently in the medical record.
9. The consent process shall be documented in the electronic health record.

Instructions:

1. The parent/guardian should receive information in their preferred language about the medication(s) before the form is completed. The child should receive age-appropriate information in their preferred language.
2. The medication(s), route(s), and dosage range(s) are entered into the table for up to five medications.
3. If the parent/guardian consents to the medication(s), the parent/guardian and the prescriber sign and date the form.
4. The client assent signature is desirable but not required.
5. If the parent/guardian verbally consents to medication(s) and is unable to sign the form, check the applicable box. The prescriber shall sign and date the form and document the reason for not signing. The prescriber documents continued attempts to obtain a signature by initialing and dating the appropriate line.
6. If the parent/guardian is unable to sign or signs with a mark, a third party witness must co-sign.
7. Prescriber signatures on the medication consent must include the person's type of professional degree, and licensure or job title.