Prescribing Practitioner

*Name (First) (Last)

*Specialty Please select option

*Address

*City

*Zip

*Phone - - ext

*Fax - -

*Email
(A copy of the report and e-mail notification of fax will be sent to the address above)

Section 1: Demographic Information

*Date of Office Visit Month Day 2011

*Child's Name (First) (MI) (Last)

*Child's Date of Birth Month Day YYYY *Age: Calculate Age

*Height (inches)

*Weight (pounds)

*BMI Calculate BMI

*Gender Male Female

*County Please select option

*Circuit

Name of submitter (if not provider or case manager)
Phone - - ext
Fax - -
Email

Case Manager / Child Welfare Staff
Phone - - ext
Fax - -

Email

(A copy of the report and e-mail notification of fax will be sent to the addresses above, if provided)

Case Manager Supervisor

Phone - - ext

Contracted Agency

Obtaining Informed Consent was attempted from the parent/guardian: Yes No Date

Section 2: Diagnosis / Disorder / Behavioral Hypothesis

*Select all that apply

- ADHD
- Anxiety Disorder
- Autism/Asperger's
- Bipolar Disorder
- Communication/Speech
- Conduct Disorder
- Depression
- Learning Disorders
- Mental Retardation
- Oppositional Defiant Disorder
- Post Traumatic Stress Disorder
- Psychosis
- Reactive Attachment Disorder
- Substance Abuse
- Other

Rule Out:

Section 3: Psychotropic Medication Planned

*Medication

- New Medication
- Requesting authorization on existing medication

Please select option

*Dose

Amount: Unit: Please select option

Route: Please select option

Frequency: Please select option

*Dosage range

Starting dose: Amount Unit: Please select option

Maximum dose: Amount Unit: Please select option

*Titration plan

Increase dose by Unit: Please select option at the following schedule

Please select option until target dose is achieved or target symptoms are alleviated.

*To address the following target symptoms

Select all that apply

- [ ] Aggression
- [ ] Anxiety
- [ ] Compulsions
- [ ] Depression
- [ ] Dysphoria
- [ ] Hallucinations
- [ ] Hyperkinesis
- [ ] Impulsivity
- [ ] Inattention
- [ ] Irritability
- [ ] Mood Instability
- [ ] Obsessions
- [ ] Self-injurious Behavior
- [ ] Stereotypies
- [ ] Thought Disorder
- [ ] Tics
- [ ] Other

*Define treatment success

Select all that apply

- [ ] Decreased frequency/duration of tantrums
- [ ] Decreased frequency/intensity of aggressive episodes
- [ ] Increased ability to attend school/daycare
- [ ] Increased ability to participate in social activities
- [ ] Increased social relatedness
- [ ] Improved caregiver-child relationship
- [ ] Reduction in target symptoms as measured by appropriate symptom assessment measures (e.g., SNAP/Vanderbilt score or CDI)
- [ ] Other

*Define monitoring plan

Example Antipsychotic Monitoring Plan: Obtain Body Mass Index (BMI) and Blood Pressure at baseline and every visit. Obtain Abnormal Involuntary Movement Scale (AIMS) at baseline and at least every 6 months, sooner if major dose change. Obtain baseline Fasting Lipid Profile (FLP) and Comprehensive Metabolic Profile (CMP). Repeat FLP and fasting glucose at 3 months, then every 6 months. Repeat CMP annually. Consider EKG.

Example Stimulant Monitoring Plan: Obtain baseline standardized rating Scale (e.g., SNAP/VANDERBILT) from caregiver and teacher and repeat with dose titration to desired effect as tolerated. Monitor blood pressure, pulse, height and weight at every visit.

If the above medication fails to meet the identified goal, the following medication is in the same drug class will be tried using monitoring plan outlined above:

Medication: Please select option

Dose: Amount: ____ Unit: Please select option

Route: Please select option

Frequency: Please select option

Dosage range: Starting dose: Amount ____ Unit: Please select option

Maximum dose: Amount ____ Unit: Please select option

Titration plan

Increase dose by [ ] Unit: [Please select option] at the following schedule

[Please select option] until target dose is achieved or target symptoms are alleviated.

[Add another planned medication]

Section 4: Other Planned Treatments / Therapies / Evaluations

*Select all that apply

- ☐ Applied behavior analysis
- ☐ Behavior modification
- ☐ Cognitive behavioral therapy
- ☐ Family therapy
- ☐ Psychoeducational testing
- ☐ Speech/language assessment
- ☐ Other

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

*Physical exam

- ○ Physical exam completed and normal
- ○ Physical exam completed and following abnormalities: [ ]

*Medical Problems

- ☐ No other medical problems

- ☐ Allergy or asthma
- ☐ Heart problems
- ☐ Gastro-intestinal problems
- ☐ Seizures
- ☐ Other

Is the child currently on other psychotropic medications?

1) [ ] 2) [ ] 3) [ ] 4) [ ]

Is the child on any other non-psychotropic medications (including over the counter)?

1) [ ] 2) [ ]

[Submit]