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 Only fill out this form if both boxes below are checked. If you can not 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 as the most recent 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 child 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 Describe the child's response to any current psychotropic medication.

8 a. Have other 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 Describe the symptoms not alleviated or ameliorated by other current or past treatment efforts.

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

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. ☐ The child's present caregiver was informed of this request, the recommended medications, the anticipated benefits, and the possible adverse reactions which include:

_____

_____

_____

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

_____

_____

_____

_____

b. ☐ The child's present caregiver was not informed of this request, the recommended medications, the anticipated benefits, and the possible adverse reactions which include:

_____

_____

_____

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 group therapy and individual therapy):*

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. Mark each psychotropic medication as Continuing (C).

Medication name (generic/brand) and symptoms targeted by each medication's anticipated benefit to child	*C or N*	*Maximum total mg/day*	*Treatment duration**	*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. why prescribing more than one medication in a class, why prescribing outside the approved range, or why 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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