CFS 431-A
Rev. 8/2006

DCFS

Illinois Department of Children & Family Services

PSYCHOTROPIC MEDICATION REQUEST FORM

Date ____________________ **Child's Name** ____________________ **CFS ID#** _ _ _ _ _ _ _ _ (8digits)

Date of Birth __________________ ☐ **Male** ☐ **Female** **Ethnicity** ____________________ **Current Height** _____ **Weight** ___

Placement: ☐ Foster Care ☐ Residential ☐ DOC ☐ Hospital ☐ Family of Origin ☐ Other ____________________

Facility Name ____________________ **Address** ____________________ **Telephone** ____________________

Prescribing Physician ____________________ **Specialty** ____________________ **Telephone** ____________________ **Fax** ____________________

Check DCFS/POS Region ☐ Cook County ☐ Northern ☐ Central ☐ Southern

Clinical Information

Concurrent Medical Diagnoses: ____________________

All Psychiatric Diagnosis: ____________________

Current Psychotropic Medications

Medication/Dosage/Frequency Medication/Dosage/Frequency Medication/Dosage/Frequency

Medication/Dosage/Frequency Medication/Dosage/Frequency Medication/Dosage/Frequency

Discontinued Psychotropic Medications: ____________________
Medication/Dosage/Frequency

Additional Info/Other Medications: ____________________

Medication Request

Check One: ☐ **New** ☐ **Increase*** ☐ **180 Day Renewal*** ☐ **Resume** ☐ **One Time Order** ☐ **New Ward, Current Medication**
**If medication request is for an Increase or Renewal include the current dosage in the Clinical Information section.*

Brand Name ____________________ Chemical Name ____________________

Form _____ Dosage ____________ Frequency ____________________ Range ____________________ Duration (not to exceed 180 days) _____

Symptoms for Medication Requested: ____________________

Tests/Procedures prior to and to monitor medication requested: ____________________

Alternative Treatment/Medications*: ____________________
*List alternative treatment methods and medications considered/attempted and the reasons they failed or were rejected.

Potential side effects reviewed with child? ☐ ***Yes*** ☐ ***No*** ***If the child is 12 years of age or older, does he/she object to medication?*** ☐ ***Yes*** ☐ ***No***

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