Consultation for Child/Youth Being Prescribed Psychotropic Medication

Send this referral form to: Sarah.Chaffee@uvmhealth.org

District Office: _____ **Social Worker:** _____

Date of Consultation: _____ **Time of Call:** _____

Consulting Psychiatrist: _____

Social Worker: Please check relevant item(s).

A. ☐ Consultation required:
- ☐ child is under age of six
- ☐ 2 or more anti-psychotic medications are recommended concurrently, except during a phase-in or phase-out period
- ☐ dosage exceeds maximum recommended
- ☐ child's parent disagrees with recommendation

B. ☐ Consultation is optional.

C. Specific question(s) or concern(s) wish to address in consultation?

Consultant: Please review the attached Consent Form for _____ ***before consultation.***
Name of child

1. Are there any items with which you disagree or have concerns?

2. Would you want to elaborate further on any items?

3. Are there other treatment options that should be considered in addition to or instead of this prescription?

4. Is the monitoring plan adequate?