I. PURPOSE

To establish procedures for obtaining informed consent for the administration of psychotropic medication to minors.

II. POLICY

Psychotropic medication shall be administered to minors under the following conditions:

A. with telephone and/or written informed consent of a parent, legal guardian or LPS Conservator

B. with a valid court order.

C. in an emergency, (See Attachment 1) with or without consent.

III. PROCEDURE

A. Efforts should be made by the psychiatrist to obtain written informed consent for medications from a patient, legal guardian or conservator at time medication is prescribed. Signed consent should be documented on the form entitled "Information/Consent for Use of Psychotropic Medications for Voluntary/ Involuntary Patients." (See Attachment 2).

1. If the parent/guardian is unable to immediately respond to the request for written informed consent the psychiatrist may obtain verbal informed consent for administration of psychotropic medications.

2. Verbal/telephone consent may be obtained only by a psychiatrist and documented on the telephone consent for medication form. (See Attachment 3).

3. Documented verbal consent is valid for 14 days. If the legal guardian is unable to sign the medication consent within 14 days, the psychiatrist will need to obtain a court order by following the procedures below.

B. If a parent, legal guardian, or Conservator is not available, is unable to sign a consent, or if a minor is a court dependent, a court order from the Juvenile Court must be obtained, authorizing medication.

1. Efforts to contact the appropriate legal guardian must be documented in the minor's medical record prior to use of a court order.

C. If a court order is deemed necessary, the attending physician shall complete the appropriate "Declaration Regarding the Need to Administer Psychotropic Medications", form (See Attachment 4), after assessing the minor to determine the specific medication required.

1. The "Declaration" form must be printed clearly or typed, and each section must be completed thoroughly.

2. When the "Declaration" form is completed by the physician, the minor's DPSS worker or Probation Officer should be contacted and asked to obtain the necessary court order/approval.

D. A faxed or xeroxed copy of a current court order, or signed medication consent from another source (e.g. DMH or other community clinic) is considered valid, provided there has been reasonable continuity in treatment services, and there have been no changes in the name of the medications or dosages beyond those stated in the consent/court order.

E. Once an informed consent or court order for psychotropic medications has been obtained, a physician may change or titrate dosages within the ranges stated in the consent/court order and may discontinue any medications as deemed necessary.

F. A court order or medication consent form may list more than one medication (e.g. Imipramine and Mellaril); however, when a new/different medication (even within the same class) is added or changed during the course of the treatment, (e.g. a change from Imipramine to Prozac) a new court order or guardian consent must be obtained.

G. If a minor objects to medication at anytime during the involuntary stay and the emergency exception is not applicable, a Riese order must be obtained. (Note: a Riese order is a judicial notice from the Mental Health Court which orders an involuntary patient to comply with prescribed pharmacological treatment).

H. See attached addendum for specific procedures to follow within the Juvenile Justice Outpatient Program (JJOP). (See Attachment 8).

ATTACHMENTS

1. Emergency Definition
2. Consent for Meds
3. Telephone Consent Form
4. Court Declaration
5. Medication Information Statement to Parents
6. Letter/Request for Parents to Sign Consent Form
7. Cover Letter Regarding Medication and Side Effects
8. Juvenile Justice Outpatient Program Medication Procedures for Incarcerated Minors

§ 853. Emergency.

Nothing in this article is intended to prohibit the physician from taking appropriate action in an emergency. An emergency exists when there is a sudden marked change in the patient's condition so that action is immediately necessary for the preservation of the life or the prevention of serious bodily harm to the patient or others, and it is impracticable to first obtain consent. If antipsychotic medication is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient.

NOTE: Authority cited: Sections 5325, 5326 and 5326.95, Welfare and Institutions Code. Reference: Sections 5325 and 5325.1, Welfare and Institutions Code; *Cobbs v. Grant* (1972) 8 Cal. 3d 229.

HISTORY:

1. Editorial correction of NOTE filed 10-26-82 (Register 82, No. 44).

SAN BERNARDINO COUNTY DEPARTMENT OF BEHAVIORAL HEALTH
INFORMATION/CONSENT TO USE OF PSYCHOTROPIC MEDICATIONS
FOR VOLUNTARY/INVOLUNTARY PATIENTS

PATIENT NAME: _____ DOB: _____

LEGAL STATUS: _____ MHU#: _____

PART I: INFORMATION

The undersigned, physician for the above-named patient, hereby certifies that I have supplied the following information regarding the administration of psychotropic medication to this patient:

1. The nature of the patient's medical condition;
2. The reasons for taking such medication, including the likelihood of improving or not improving without such medication, and that consent, once given, may be withdrawn at any time by stating such intention to any member of the treating staff;
3. The reasonable alternative treatments available, if any;
4. The type, range of frequency and amount (including the use of PRN orders), method (oral or injection), and duration of taking the medication;
5. The probable side effects of these drugs known to commonly occur, and particular side effects likely to occur with the particular patient;
6. The possible additional side effects which may occur to patients taking such medication beyond three months. The patient shall be advised that such side effects may include persistent involuntary movement of the face or mouth and might, at times, include similar movement of the hands and feet, and that these symptoms of tardive dyskinesia are potentially irreversible and may appear after the medications have been discontinued.
7. Printed information on medications given to patient: YES_____ NO_____
   If answer is NO, WHY NOT?_____

_____ _____
DATE/TIME SIGNATURE OF PHYSICIAN

PART II: CONSENT

The undersigned above named patient, hereby acknowledges that:

1. All the information above regarding the administration of psychotropic medications has been fully explained to me;
2. I understand this information and have no further questions at this time;
3. I understand that if I have questions after I have taken this medication, I will have an opportunity to discuss them with my physician;
4. I understand that nothing in this article prohibits a physician from taking appropriate action in an emergency;
5. I understand that I can withdraw this consent at any time by telling a member of the treatment staff.

I DO CONSENT TO THE USE OF: (list specific names of medications)

_____

_____ _____
DATE/TIME SIGNATURE OF PATIENT

CONFIDENTIAL PATIENT INFORMATION
SEE W&I CODE 5328
297X (Revised 8/89)

Verbal/Telephone Consent for Administration of Psychotropic Medication

On this date _____/_____/19_____, telephone consent was given by

_____, that his/her _____,
parent, guardian, conservator relationship

_____, _____, may be given the
name DOB

following medication(s)_____

_____

as determined by Dr._____, who advised

_____, concerning medications and
parent/guardian, conservator

side effects as noted in Attachment 2 (Medication Consent) and Attachment 5 (Medication Information).

/ / On_____, _____
date parent, guardian, conservator

agreed to come to this facility by_____, to sign
date

the Consent for Medication.

_____ _____
Psychiatrist Date

JOHN MICHAELSON, Director
Department of Children's Services
By _____
Office _____
Phone _____
Petitioner

TO HON._____
☐ Judge ☐ Commissioner ☐ Referee
Department: JUV-_____-_____
Date_____ Master J No._____

For Court Use Only

SUPERIOR COURT OF CALIFORNIA,
COUNTY OF SAN BERNARDINO
JUVENILE DIVISION

In the matter of

J No._____

☐ **REGARDING THE NEED TO ADMINISTER PSYCHOTROPIC MEDICATION AND ORDER AUTHORIZING ADMINISTRATION OF PSYCHOTROPIC MEDICATIONS; ORDER THEREON.**

☐ **EMERGENCY PSYCHOTROPIC MEDICATION ADMINISTERED PURSUANT TO WIC 5008.**

- PLEASE TYPE -

MEDICAL INFORMATION/RECOMMENDATION (to be completed by physician)

Minor's Name_____ Age_____ Weight_____ M F

Minor's Present Placement (location):_____

Prescribing Physician (print)_____ Phone_____

Hospital Affiliations:_____;_____

Specialty:

☐ Psychiatrist ☐ General/Family Practice ☐ Pediatrician ☐ Neurologist ☐ Other_____

I (prescribing physician)_____hereby declare:

1. That the use of psychotropic medications is required to control the symptoms of (diagnosis) _____

_____

_____

_____

which in this case include (behaviors/moods, etc. observed by myself or others)

_____

_____

_____

for the above-named patient.

NAME:
CHART NO.:
DOB:

2. The following attempts have been made to have the parent/guardian sign an authorization/consent form for the administration of psychotropic medications to the patient:

____ Location of parent(s) has been unknown for _____ months

____ Telephone

____ Letter

____ No known guardian

____ Refused (discussed with family)

____ Letter of Consent packet mailed but not returned

____ Other (specify) _____

3. The minor is over age 14 and (check one): ☐ Has ☐ Has Not consented to take the medication.

4. **TREATMENT PLAN:**

☐ A. **EMERGENCY TREATMENT GIVEN:**

Starting on _____ (date) it was necessary to provide emergency treatment to the above-named patient because _____

_____

_____

(See Item 9 for applicable attachments.)

Minor was evaluated for administration of this medication on: _____.

The following medication(s) were administered within a dosage range the medical profession considers acceptable for a patient of this age and weight. *(See highlighted attachments for common side effects of this medication and recommended dosage ranges for this type of patient.)*

Categories that were administered (check all that apply):

☐ Antiseizure ☐ Antidepressant (Non MAOI) ☐ Antipsychotic ☐ Anti-manic

☐ Antihyperactivity ☐ Anti-anxiety/hypnotic ☐ MAOI (Monoamine Oxidase Inhibitor)

Medication	Purpose	Starting Daily Dose	Maximum Daily Dose

NAME:
CHART NO.:
DOB:

☐ **B. PROPOSED TREATMENT PLAN (NON EMERGENCY):**

The following medication(s) **will be** administered within a dosage range the medical profession considers acceptable for a patient of this age and weight. *(See highlighted attachments for common side effects of this medication and recommended dosage ranges for this type of patient)* **Minor was evaluated for administration of this medication on** _____.

***Categories to be administered (check all that apply)*:**

☐ Antiseizure ☐ Antidepressant (Non-MAOI) ☐ Antipsychotic ☐ Anti-manic

☐ Antihyperactivity ☐ Anti-anxiety/hypnotic ☐ MAOI (Monoamine Oxidase Inhibitor)

Medication	Purpose	Starting Daily Dose	Maximum Daily Dose

C. This treatment plan will commence upon the physician's receipt of this signed consent.

D. Expected duration of treatment: _____

_____

E. Additional side effects due to drug interactions or other medical conditions unique to this patient: _____

_____

5. Administration of the above medication(s) is recommended because:

✓ Anticipated Benefits (Goals):_____

_____

✓ Describe any other less restrictive/less intrusive treatment alternatives that have been attempted or considered. Explain those that were considered and why they are not recommended at this time:_____

_____

_____

6. If this medication is not authorized, the probable consequences to the minor are (e.g. likelihood of improving if the medication is not authorized):_____

_____

_____

NAME:
CHART NO.:
DOB:

7. It is my understanding that the above-named patient has a prior history of being medicated with psychotropic medication, to wit: (list date, name of medication, dosage, etc.).

Medication	Dosage	Date Given	Purpose	Date Discontinued

8. The following foods, medications, or activities should be eliminated or curtailed while minor is on the above medication (e.g. operating equipment or motor vehicles, drinking milk).

_____

_____

_____

_____

9. ☐ A status/diagnostic report or progress notes on the above-named patient are attached.

I declare, under penalty of perjury, that the information in the foregoing Paragraphs 1 through 9 is true and correct to the best of my knowledge.

Executed at San Bernardino County, California on the date shown.

_____ Physician's Signature

_____ Date

NAME:

CHART NO.:

DOB:

Minor's Att._____	**Fa's Att.**_____
Phone Notice Date: ☐ **Agreed** ☐ **Message Left** _____ ☐ **Object**_____	**Phone Notice Date:** ☐ **Agreed** ☐ **Message Left** _____ ☐ **Object**_____
☐ **Set for Hearing** ☐ **See Attached**	☐ **Set for Hearing** ☐ **See Attached**
Mo's Att._____	**Att. for**_____
Phone Notice Date: ☐ **Agreed** ☐ **Message Left** _____ ☐ **Object**_____	**Phone Notice Date:** ☐ **Agreed** ☐ **Message Left** _____ ☐ **Object**_____
☐ **Set for Hearing** ☐ **See Attached**	☐ **Set for Hearing** ☐ **See Attached**

Distributed to attorneys ☐ G.A.L. on (Date)_____ by (DCS Clerk's initials) _____. Judge/Commissioner will make appropriate orders 5 court days after date of distribution unless Matter set for Hearing.

ORDER

Upon reading the sworn declaration, and good cause appearing,

IT IS HEREBY ORDERED that psychotropic medications are authorized for the above-named patient as noted in Paragraph 4 of the above declaration.

IT IS HEREBY ORDERED that emergency treatment provided is approved nunc pro tunc under W & I Code Section 5008.

This Order expires on _____.

Dated:_____

County Clerk_____

Signed:_____
☐ Judge ☐ Commissioner ☐ Referee Of The Superior Court

NAME:
CHART NO.:
DOB:

STATEMENT TO PARENTS

After appropriate evaluation and consideration of alternatives, the Medication and Treatment Plan described has been prescribed for your child. If you have any questions concerning this Treatment Plan, you should contact the facility where your child is being treated.

COMMON SIDE EFFECTS OF MEDICATION

I. ANTIPSYCHOTICS

Dry mouth, constipation, dry skin, drowsiness, sweating, stuffy nose, blurred vision, moderate breast enlargement or discharge, difficulty in urinating, weight gain, menstrual irregularities and lightheadedness.

Additional side effects have been reported to rarely occur when taking antipsychotic medication(s) for extended periods, and include persistent involuntary movement of the face, mouth, hands, or feet. These symptoms of tardive dyskinesia are potentially irreversible and may appear after medication(s) have been discontinued.

II. ANTIDEPRESSANTS

Dry mouth and skin, constipation, drowsiness, blurred vision, menstrual irregularities, difficulty urinating, sweating, headache sexual dysfunction, insomnia, breast tenderness or secretion, muscle tremors, weight gain or rapid heartbeat.

III. MAOI (Monamini Oxidase Inhibitor/Antidepressant)

Blood pressure changes, rapid heart beat, dizziness, constipation, rash, insomnia.

IV. LITHIUM

Mild nausea, vomiting, diarrhea, metallic taste, excessive thirst, increased urination, mascular weakness, tremor of hands, acne-like skin rash.

V. ANTI-HYPERACTIVITY

Nervousness, insomnia, anorexia, stomachaches, rashes and headache.

VI. ANTI-ANXIETY/HYPNOTICS

Drowsiness, fatigue, constipation, sedation, dizziness, weakness and nausea.

VII. ANTI-SEIZURE

Depression, drowsiness, ataxia, emotional upset, hair loss, skin rash and slurred speech, glossitis and gum hypertrophy.

Other more serious complications have been reported to rarely occur.

DEPARTMENT OF BEHAVIORAL HEALTH

COUNTY OF SAN BERNARDINO
HUMAN SERVICES SYSTEM

ıst Gilbert Street • San Bernardino, CA 92415-0920 • (909) 387-7053

RUDY G LOPEZ
Director of Behavioral Health

Re:

Dear:

Your child is currently in a Juvenile Institution operated by the County Behavioral Health Department, and we are trying to provide mental health services for him/her. One service currently being provided by our mental health clinic is medicine which is technically called "psychotropic medication." These are medicines which are used to treat serious mental and emotional symptoms. We would like to have your consent as the child's parent/guardian, to continue this treatment. Please review the attached consent form and the medication information which is included in this packet.

If you have any questions, feel free to call this clinic or the physician at the Department of Behavioral Health who is treating your child. If you consent to your child taking these medications, please sign the consent form and return it within 14 working days in the enclosed envelope. If we do not hear from you, it may be necessary for the County to request a court order authorizing administration of psychotropic medications to your child.

If there are any questions about your child's treatment, please call _____.

Sincerely,

Behavioral Health Clinical Therapist

DEPARTMENT OF BEHAVIORAL HEALTH

COUNTY OF SAN BERNARDINO
HUMAN SERVICES SYSTEM

.ast Gilbert Street • San Bernardino, CA 92415-0920 • (909) 387-7053

RUDY G LOPEZ
Director of Behavioral Health

Dear Parent:

Your child was referred for a medication evaluation. The presenting problem was _____

_____

_____

Our psychiatrist would like to prescribe the following medication: _____

_____

Attached is a list of possible side effects. Should you wish to discuss this with the doctor, please call (909) 387-6942 between 1-4 P.M. on Monday, Tuesday, or Thursday of any week. We cannot start mediation without your signature on the attached medication consent form. Please return as soon as possible if you agree your child could benefit from medication. Thank you for your time and cooperation.

Yours truly,

Clinical Therapist
(909) 387-6942

DEPARTMENT OF BEHAVIORAL HEALTH

COUNTY OF SAN BERNARDINO
HUMAN SERVICES SYSTEM

ast Gilbert Street • San Bernardino, CA 92415-0920 • (909) 387-7053

RUDY G LOPEZ
Director of Behavioral Health

Dear Parent:

Your child was referred for a medication evaluation. The presenting problem was _____

_____

_____

Our psychiatrist would like to prescribe the following medication: _____

_____

Attached is a list of possible side effects. Should you wish to discuss this with the doctor, please call _____ between 1:00-4:00 P.M.

We cannot start mediation without your signature on the attached medication consent form. Please return as soon as possible if you agree your child could benefit from medication.

Thank you for your time and cooperation.

Yours truly,

Clinical Therapist

**----------