

Attachment 4

JV 220; JV 220a

Can be found on the following website:

<http://www.courtinfo.ca.gov/selfhelp/family/allforms.htm>



RIVERSIDE COUNTY DEPARTMENT OF MENTAL HEALTH

Jerry A. Wengerd, Director

Reply to: Outpatient Quality Improvement
 P.O. Box 7549
 Riverside, CA 92513
 (951) 955-7320
 Fax (951) 955-7203

This fax cover sheet must be completed and used when submitting a Medication Declaration.

Date: _____

To: Quality Improvement Outpatient

Fax # (951) 955-7203

From: _____

Address _____

Phone # _____

Fax # _____

Client Name: _____

Social Security # of client _____

Page 1 of _____ pages

PROPOSED TREATMENT AND FOLLOW UP SERVICES

Referral Source: ACT CAT TRACT

Psychiatric Evaluation _____ Session(s) per week/month for _____ weeks/months (15, 30, 60 min.)

Collateral Visit _____ Session(s) per week/month for _____ weeks/months (30, 60 min.)

Collateral Sessions with: _____

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“Confidential Client Information - See California W & I Code 5328”

<http://rcdmh.org> ♦ www.riverside.networkofcare.org

**Application Regarding
Psychotropic Medication**

Attach a completed and signed JV-220(A), *Prescribing Physician's Statement—Attachment*, with all its attachments, must be attached to this form before it is filed with the court. Read JV-219-INFO, *Information About Psychotropic Medication Forms*, for more information about the required forms and the application process.

- ① Information about where the child lives:
- a. The child lives with a relative in a foster home
 with a nonrelative extended family member
 in a regular group home in a level 12–14 group home
 at a juvenile camp at a juvenile ranch
 other (*specify*): _____
- b. If applicable, name of facility where child lives: _____
- c. Contact information for responsible adult where child lives:
 (1) Name: _____
 (2) Phone: _____

- ② Information about the child's current location:
- a. The child remains at the location identified in ①.
- b. The child is currently staying in:
 (1) a psychiatric hospital (*name*): _____
 (2) a juvenile hall (*name*): _____
 (3) other (*specify*): _____

- ③ Child's social worker probation officer
- a. Name: _____
- b. Address: _____
- c. Phone: _____ Fax: _____

④ Number of pages attached: _____

Date: _____

Type or print name of person completing this form

Signature

- Child welfare services staff (*sign above*)
 Probation department staff (*sign above*)
 Medical office staff (*sign above*)
 Caregiver (*sign above*)
 Prescribing physician (*sign on page 3 of JV-220(A)*)

Clerk stamps date here when form is filed.

Fill in court name and street address:

Superior Court of California, County of _____

Fill in child's name and date of birth:

Child's Name: _____

Date of Birth: _____

Clerk fills in case number when form is filed.

Case Number: _____

This form must be completed and signed by the prescribing physician. Read JV-219-INFO, *Information About 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 Type of request:
 a. An initial request to administer psychotropic medication to this child
 b. A request to continue psychotropic medication the child is currently taking
- ③ This application is made during an emergency situation. The emergency circumstances requiring the temporary administration of psychotropic medication pending the court's decision on this application are:

- ④ 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*): _____
- ⑤ 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*): _____

- ⑥ Information about child provided to the prescribing physician by (*check all that apply*):
 child caregiver teacher social worker probation officer parent
 records (*specify*): _____
 other (*specify*): _____
- ⑦ Describe the child's symptoms, including duration as well as the child's response to any current psychotropic medication. If the child is not currently taking psychotropic medication, describe treatment alternatives to the proposed administration of psychotropic medication that have been tried with the child in the last six months. If no alternatives have been tried, explain the reasons for not doing so.
 Presenting problems (Target symptoms): _____

 Duration of symptoms: _____
 Response to current meds: NA / Poor / Fair / Good
 Alternatives: None / _____
 Response to alternatives: Poor / Partial / Good / Not tried due to: _____

Child's name: _____

8 Diagnoses from *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* (provide full Axis I and Axis II diagnoses; inclusion of numeric codes is optional):

9 Therapeutic services, other than medication, in which the child will 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. Other modality (explain): _____

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):

b. Relevant laboratory tests performed or ordered (optional information; provide if required by local court rule):
 kidney function liver function thyroid function UA glucose lipid panel
 CBC EKG pregnancy medication blood levels (specify): _____
 other (specify): _____

11 **Mandatory Information Attached:** Significant side effects, warnings/contraindications, drug interactions (including those with continuing psychotropic medication and all nonpsychotropic medication currently taken by the child), and withdrawal symptoms for each recommended medication are included in the attached material.

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 other (explain): _____
 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 is too young.
 (2) the child lacks the capacity to provide a response (explain): _____
 (3) other (explain): _____

13 The child's present caregiver was informed of this request, the recommended medications, the anticipated benefits, and the possible adverse reactions. The caregiver's response was agreeable other (explain):

14 Additional information regarding medication treatment plan: _____

Case Number:

Child's name:

- 15 List all psychotropic medications currently administered that you propose to continue and all psychotropic medications you propose to begin administering. Mark each psychotropic medication as New (N) or Continuing (C). Administration schedule is optional information; provide if required by local court rule.

<i>Medication name (generic or brand) and symptoms targeted by each medication's anticipated benefit to child</i>	<i>C or N</i>	<i>Maximum total mg/day</i>	<i>Treatment duration*</i>	<i>Administration schedule (optional)</i> • 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: Targets:				
Med: Targets:				
Med: Targets:				
Med: Targets:				
Med: 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.

- 16 List all psychotropic medications currently administered that will be stopped if this application is granted.

<i>Medication name (generic or brand)</i>	<i>Reason for stopping</i>

- 17 List the psychotropic medications that you know were taken by the child in the past and the reason or reasons these were stopped if the reasons are known to you.

<i>Medication name (generic or brand)</i>	<i>Reason for stopping</i>

Date:

Type or print name of prescribing physician

Signature of prescribing physician