*To be completed by the medical practitioner*

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| *The purpose of this form is to obtain the guardian’s consent for the use of psychotropic medication prescribed by a medical practitioner for a child subject to a child protection order granting custody to the chief executive.* |

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| --- | --- | --- | --- | --- | --- |
| **Child’s name:** |  | **DOB:** |  | Age: |  |
| **What medications is the child currently taking?** | | | | | |
|  | | | | | |

| **Part A – Prescribed medication and purpose of the medication (completed by the medical practitioner)** | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of medication** | **Dose range** | **Method of adminis-trating** | **Frequency** | **Fixed dose or PRN** | **Reason for Medication (Please tick applicable – one box per row only)** | | | **Please specify the condition that the medication is being prescribed for** |
| **Treatment of a diagnosed mental health condition (eg. anxiety, depression, suicidal ideation)** | **Treatment of a diagnosed neurological or physical condition (eg. ADHD, epilepsy)** | **Primary purpose of controlling the person’s behaviour (eg. aggressive behaviour related to autism)\*** |
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| **What are the benefits of taking this medication? (eg. reduced anxiety)** | |
|  | |
| **What is the consequence for the child of not having the medication?** | |
|  | |
| **What are the potential side effects? (consider providing a medication leaflet)** | |
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| **Any recommendations to minimise the risk of side effects? (eg, metabolic monitoring)** | |
|  | |
| **Review period:** |  |

|  |  |  |  |
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| **Details of the prescribing medical practitioner:** | | | |
| **Name of medical practitioner:** |  | **Signature:** |  |
| **Hospital / Medical Centre:** |  |

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| Part B – Reason for seeking the medication (completed by CSSC staff) |

*The decision to prescribe or alter psychotropic medication for a child in care is a serious decision. The child’s guardian needs to have detailed information about the reason for the prescription of psychotropic medication.*

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| **Reason for seeking the medication:** (child’s specific circumstances, effectiveness of previous treatments and/or behaviour support strategies) | |
|  | |
| **Is the medication primarily for controlling behaviours?** | □ Yes □ No |
| ***Note:*** *Medication that is prescribed primarily for controlling behaviours is a chemical restraint and therefore a restrictive practice. Where the primary purpose of the medication is to control a child’s behaviour, immediately refer the matter to Specialist Services for support and advice, via email* [SDSpecialistservices@csyw.qld.gov.au](mailto:SDSpecialistservices@csyw.qld.gov.au) *and answer the following questions.* | |
| **What other strategies are proposed?** (eg: safety and support plan, positive behaviour support plan, access to therapeutic services, support to improve sleep hygiene) | |
|  | |
| **Has the prescription of this psychotropic medication been discussed with the child? If yes, what were their views and wishes?** | □ Yes □ No |
|  | |

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| **Consent decision for the prescribed medication (to be completed by the child’s parent) - see attached:**  **Parental consent for psychotropic medication (child in custody of the chief executive)** |

***Attach the original consent form to the child’s health care file and provide a copy of the form to the medical practitioner, the parents (when appropriate) and the carer for inclusion in the child’s Child Health Passport.***

In an EMERGENCY, please contact [Insert contact name] at the [xxxx] Child Safety Service Centre on [insert telephone number] or Child Safety After Hours Service Centre.

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| **Privacy notice**  The *Child Protection Act 1999 (the Act)* authorises the Department of Children, Youth Justice and Multicultural Affairs to collect the information on this form to facilitate decision-making around the use of psychotropic medication for a child in care. The Department of Children, Youth Justice and Multicultural Affairs may provide some or all of this information to a relevant tribunal or court or person as authorised under the Act. All information provided by a medical practitioner will be managed in accordance with the Information Privacy Principles described in the *Information Privacy Act 2009*. |

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Part C - Consent decision (completed by the parent) | | | | | | | |
| Name of parent |  | | Parent of | |  | | |
| Parent’s address |  | | | | | | |
| Intervention type | □ Child protection order - custody to the chief executive  □ Child protection care agreement - custody to the chief executive | | | | | | |
| □ Yes □ No | I have reviewed the reasons for prescribing the medication, its effects and possible side effects, as described in the information provided above by the doctor. | | | | | | |
| I hereby: | □ consent □ do not consent | to the prescribed psychotropic medication being administered to my child for the reasons outlined in this form. | | | | | |
| Signed |  | | | | | | |
| Name |  | Date | |  | | Telephone |  |