STATE OF RHODE ISLAND AND PROVIDENCE PLANTATION
Department of Children, Youth and Families
101 Friendship Street
Providence, RI 02903

REQUEST FOR ADMINISTRATOR AUTHORIZATION

Child's Name: _____ DOB: _____

Prescribing Physician (Print & Sign)_____ Date: _____

_____

Phone Number: ( ) _____

Current Diagnosis: _____

_____

_____

Questions to ask Physician:

Current Medications: _____

(incl over the counter) _____

_____

_____

New Medication Prescribed: _____

Discontinued Medication: _____

Known Medication Allergies: _____

Explanation for New Medication

and/or Modification of Medication: _____

_____

_____

Anticipated Benefits: _____

_____

Possible Side Effects (Including Potential Drug Interactions: _____

_____

_____

Has Consideration been given to Medical Conditions and Related Medications? Please Describe:

_____

_____

_____

Required Follow Up (e.g. Medication Monitoring, Blood Levels, etc.): _____

_____

Recommended Clinical Follow Up (e.g. Individual, Psycho-Therapy, Group, Family, etc.): _____

_____

DCYF Administrator Comments: _____

_____

Authorizing Signature: _____ Date: _____

DCYF Form #207
For use with DCYF Protocol 1300.0052: Psychotropic Medication Review Plan