

### Certification of Need for Psychoactive Medication Treatment

*To be signed by a physician*  
**Please type or print clearly**

Facility Name	Vendor Number
Individual's Name	Social Security Number

<b>Department Use</b>
Case Number (to be assigned by SDM)

Physician's Name	Specialty	Office Area Code and Telephone Number
Office Address (Street, City, State, ZIP)		Fax Area Code and Telephone Number

I have been treating this individual since \_\_\_\_\_.

I believe the individual has the following psychiatric condition and/or maladaptive behavior:
My diagnosis is based on the following dominant characteristics exhibited by this individual: <b>(Please list.)</b>
The following course of therapy with psychoactive medication(s) is proposed: <b>(List the proposed medication(s), dosage and frequency.)</b>

**Risks and Benefits:** You may attach prepared documents that state the risks and benefits of the proposed psychoactive medication(s) specified, however, all questions must be addressed on this Certification of Need form.

**In my clinical opinion:**

The risks of the proposed treatment with psychoactive medication(s) are indicated: <input type="checkbox"/> Below <input type="checkbox"/> Attached
The need for and benefits of the proposed treatment with psychoactive medication(s) is indicated: <input type="checkbox"/> Below <input type="checkbox"/> Attached

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**Alternatives:**

Are there alternative treatments/procedures available to this individual? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, complete the following items (a. through e.):
a. The alternative treatments/procedures are indicated: <input type="checkbox"/> Below <input type="checkbox"/> Attached
b. The risks of the alternatives listed are indicated: <input type="checkbox"/> Below <input type="checkbox"/> Attached
c. The benefits of the alternatives listed are indicated: <input type="checkbox"/> Below <input type="checkbox"/> Attached
d. The alternatives were: <input type="checkbox"/> Attempted, but unsuccessful <input type="checkbox"/> Not attempted and rejected
<b>Explanation:</b>
e. The proposed treatment with psychoactive medication(s) is preferred to the alternatives because:

The risks of non-treatment are indicated: <input type="checkbox"/> Below <input type="checkbox"/> Attached
Are laboratory test parameters within normal limits for initiation and/or continuation of the proposed psychoactive medication(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain:
Recommended monitoring for side effects and/or adverse reaction is as follows: (Send copy of most recent AIMS.)

In your opinion, does the individual understand the proposed risks, benefits and alternatives to the proposed psychoactive medication(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No
The individual's expressed opinion about the proposed psychoactive medication(s), if any, is:

<b>Department Use</b>
_____
Case Number (to be assigned by SDM)

The above information and statements are, to the best of my knowledge, truthful and complete.

\_\_\_\_\_  
Printed Name – Health Care Professional Proposing Treatment      Signature – Health Care Professional Proposing Treatment      Date

If someone other than a physician is proposing treatment, provide name and signature of the delegating physician:

\_\_\_\_\_  
Printed Name – Delegating Physician      Signature – Delegating Physician      Date

If someone other than a health care professional completed this Certification of Need for Psychoactive Medication, provide the following information about that person:

\_\_\_\_\_  
Printed Name      Signature      Date

\_\_\_\_\_  
Title      Employer's Name

Send completed form to:  
Surrogate Decision Making Program  
Texas Department of Aging and Disability Services  
Consumer Rights and Services  
701 West 51<sup>st</sup> St.  
Mail Code E-249  
Austin, TX 78751

If you have questions or need assistance:  
Call: 512-438-4275; 512-438-4193;  
512-438-4573;  
Fax: 512-438-2883