**BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION**

***PART ONE: HEALTH SERVICES REPORT***

(To be completed by agency/residential staff (e.g. nurse, program specialist) prior to psychotropic medication)

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| **INDIVIDUAL:** | | | **DATE-PSYCHOTROPIC MED REVIEW:** |
| **ADDRESS:** | | | **PREVIOUS REVIEW:** |
| **DATE OF BIRTH:** | | | **PHYSICIAN’S NAME:** |
| **(Insert Agency Name) CONTACT:** | | | **OFFICE ADDRESS:** |
| **CONTACT PHONE:** | | | **OFFICE PHONE:** |
| **CURRENT MEDICATIONS** (*Please list* ***all*** *medications, including over-the-counter, dietary supplements, etc.* ***Attach additional pages if necessary. Include the individual’s name and date of review on every page.****)* | | | |
| **MEDICATION NAME** | **DOSAGE** | **FREQUENCY** | ***Reason for Administration*** |
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| **ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS?** NO  YES  *If “****YES****,” Specify and describe all symptoms:* | | | |
| **HAS THIS DIAGNOSIS CHANGED? SEE PAGE 3**  **and check if updated:** | **DIAGNOSIS** (*5-Axis Diagnosis from a physician, as documented in medical records)* | | **TARGET SYMPTOMS** *(BEHAVIORAL DESCRIPTION)* ***Target Symptoms listed here must match those listed on Part 2*** |
| **AXIS I**  ***(MH Diagnosis)*** |  | |  |
| **AXIS I (2)** |  | |  |
| **AXIS II**  ***(MR Diagnosis)*** |  | |  |
| **AXIS II *(Personality Disorder)*** |  | |
| **AXIS III**  ***(All Medical Diagnoses)*** |  | | |

**AXIS IV** *(Psychosocial Stressors):* as documented by physician/medical records. Notify physician if new issues/changes. **Check all that apply:**

Problem with primary support group  Problems with access to health care services  Housing problems

Problems related to the social environment  Occupational problems

Educational problems  Problems related to the judicial system

Other psychosocial/environmental problems  Economic Problems

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**AXIS V** *(Global Assessment of Functioning/GAF)* ***Score (0-100)******(Score provided by physician per DSM scale)***

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**Last Tardive Dyskinesia Screening (e.g. AIMS test): (Include date and result – required every 6 months)**

**Score:** **Date****:       \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENT HEALTH STATUS/MEDICAL ISSUES OF NOTE** *(Attach significant lab and diagnostic study results):*

***CHECK*** *all items that were an issue since the last psychotropic medication review. Add comments whenever possible.*

appetite +/- constipation dry mouth nausea/vomiting swelling alcohol use

bruising cough incontinence seizures weight +/- nicotine use

congestion diarrhea menstrual change thirst pain caffeine use

**COMMENTS OR SYMPTOMS NOT INCLUDED IN ABOVE LIST**: *(Please describe)*  other drug use

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| --- | --- | --- |
| ***Printed*** *name* ***and*** *signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report.* | | |
| **Completed by:** *(Printed Name and Signature):* | **Title:** | **Date Signed:** |
| **Agency Nurse Review:** *(Printed Name & Signature):* | **Title:** | **Date Signed:** |