**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

|  |
| --- |
| ***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:** |