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

***PART TWO: BEHAVIOR SUPPORT TREATMENT REPORT***

(To be completed by behavior specialist, QMRP, program specialist, family member prior to review.)

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| **INDIVIDUAL:** | **DATE-PSYCHOTROPIC MED REVIEW:** |
| **TARGET SYMPTOMS BEING DOCUMENTED***Include* ***BEHAVIORAL DESCRIPTIONS*** *of Target Symptoms for each mental health diagnosis listed on Axis1 on Part 1 of this form. Behavioral descriptions must be* ***specific to the individual.*** *For each target symptom,* ***fill in the number of occurrences for the past month.*** *Additional charts/graphs may be attached.* ***Add comments wherever possible.*** |
| **Target Symptoms** (from Part 1)BEHAVIORAL DESCRIPTION(**MUST MATCH** those listed on Part 1) | **Month’s Data***Fill in frequency of each symptom***Wk1 Wk2 Wk3 Wk4** | ***Comments*** |
| 1)       |       |       |       |       |       |
| 2)       |       |       |       |       |       |
| 3)       |       |       |       |       |       |
| 4)       |       |       |       |       |       |
| 5)       |       |       |       |       |       |

**ADDITIONAL CONCERNS SINCE LAST REVIEW**

Check any symptoms or environmental changes *not being documented above* that have appeared since the last review (clarify in Additional Comments section below)

[ ]  Activity Level (increased or decreased) [ ]  Obsessive-Compulsive Behavior [ ]  Unusual Body Movements (i.e., tremors)

[ ]  Anxiety [ ]  Sleep Changes [ ]  Other (Specify:

[ ]  Appetite (Increased or decreased) [ ]  Suicidal Ideation/Behavior [ ]  None

[ ]  Change in Mood [ ]  Environmental Issues [ ]  Psychotic Symptoms

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| *Were there any* ***incidents*** *related to the individual’s behavioral health diagnosis or target symptoms? Check the box if so, and insert number of occurrences.*[ ] ER visits?       [ ] Psychiatric Hospitalizations?       [ ] Restraints?       |
| **ADDITIONAL COMMENTS** |
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| **Signature(s) indicate that prior psychotropic medication review reports were reviewed in preparing this report. *This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 30 DAYS MINIMUM.*** |
| **SUMMARY COMPLETED BY:**Name:      | **Date form completed:** |
| Role: | **Date reviewed with team:** |
| Signature: | **Date reviewed w/prescribing physician:** |