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

***PART THREE: PHYSICIAN’S REPORT*** *(To be completed by physician prescribing psychotropic medication)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **INDIVIDUAL:** | | | | | |
| **DATE OF PRESENT PSYCH MED REVIEW:** | | | **DATE OF NEXT PSYCH MED REVIEW:** | | |
| ***PHYSICIAN’S AGREEMENT WITH CURRENT DIAGNOSES AND TARGET SYMPTOMS*: (see Page 1 and Page 2)**  Do the diagnos(es) in Part 1 and the target symptoms in Part 2 remain as indicated on Part 1: *Health Services Report* and Part 2: *Behavior Support Treatment Report*?  **Yes**  **No**  If **NO**, *please change to:* | | | | | |
| **TREATMENT GOALS (Regarding Target Symptoms listed on Parts 1 and 2):** | | | | **PROGRESS TOWARD GOALS:** | |
| Psychotropic medications are necessary?  Yes  No | | | | |  |
| Psychotropic medication dosages are within usual range?  Yes  No | | | | |  |
| Number of drugs conforms to accepted standards?  Yes  No | | | | |  |
| Are medication side-effects present? *(i.e., sedation, ataxia, dyscrasia*)  Yes  No | | | | |  |
| Screening test performed ( i.e., AIMS)?  Yes  No | | | | |  |
| Symptoms of T.D. or other E.P.S.?  Yes  No | | | | |  |
| Medication reduction/titration plan considered?  Yes  No | | | | |  |
| **PHYSICIAN’S ORDERS** | | | | | |
| **MEDICATION CHANGE:**  **NO**  **YES *(provide information below)*** | | | | | |
| ***NEW MEDICATION*** *(List medication, dosage & frequency)* | | | **REASON FOR NEW MEDICATION**  **Medication Education Provided?** **Yes** **No** | | |
| **Medication** | **Dosage** | **Frequency** |
| 1) |  |  |  | | |
| 2) |  |  |  | | |
| 3) |  |  |  | | |
| ***MEDICATION CHANGE*** *(List med, dosage & frequency)* | | | **REASON FOR MEDICATION CHANGE**  **Medication Education Provided?** **Yes** **No** | | |
| **Medication** | **Dosage** | **Frequency** |
| 1) |  |  |  | | |
| 2) |  |  |  | | |
| 3) |  |  |  | | |
| ***MEDICATION******DISCONTINUED*** *(List med dose, frequency)* | | | **REASON FOR MEDICATION DISCONTINUATION**  **Medication Education Provided?** **Yes** **No** | | |
| **Medication** | **Dosage** | **Frequency** |
| 1) |  |  |  | | |
| 2) |  |  |  | | |
| 3) |  |  |  | | |
| **LAB STUDIES, DIAGNOSTIC TESTS & FREQUENCIES: Metabolic screening done?** **Yes** **No Date:** | | | | | |
| **COMMENTS/CHANGES/REASONS/AREAS OF CONCERN:** | | | | | |
| *My signature below indicates that I have reviewed the Health Services and Behavior Support Treatment Reports. I have reviewed y recommendations, as well as the consequences to the individual for not following my recommendations with all parties attending this review.* | | | | | |
| **Physician’s Printed Name, Signature and Date:** | | | **Clinician: Signature, Title and Date:** | | |
| **Individual’s Consent for Psychotropic Medication: Signature and Date:** | | | | | |
| **Medical Decision-Maker’s consent: Signature and Date:** | | | | | |