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

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

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| **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:** |