GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES
DEVELOPMENTAL DISABILITIES ADMINISTRATION

PSYCHOTROPIC MEDICATION REVIEW FORM

Pages 1 and 2 of this form MUST be completed for every appointment and attached to the consult sheet for review with the prescribing physician

Person's Name:	**Appointment Date:**
Date of Birth:	**Age:**
Residential Provider:	**Residential Provider Contact:**
Day Services Provider:	**Day Services Contact:**
Physician's Name:	**Date of last quarterly Psychotropic Medication Review:**

CURRENT DIAGNOSES: Do not include diagnoses "by history," diagnoses that are resolved, or medical conditions that have resolved

Psychiatric Diagnosis	
Intellectual/Developmental Diagnosis	
Medical Diagnosis	

CURRENT MEDICATIONS: List all medications with dosages **OR** attach most recent Medication Administration Record (MAR) to this form

Medication	Dosage, Route, Frequency	Reason for medication

PSYCHOTROPIC MEDICATION CHANGES WITHIN THE LAST YEAR (*e.g.,* "Risperdone decreased from 3 mg per day to 2 mg per day")

Date	Medication Change	Reason for Change

ALLERGIES: **CURRENT WEIGHT:**

LAST TARDIVE DYSKINESIA SCREEN (e.g., AIMS, MOSES) Score: __ Date:__ Not applicable:__

ABNORMAL LABORATORY RESULTS since the last medication review. Only include abnormal results verified by a medical professional

Date	Test	Abnormal Result		Date	Test	Abnormal Result

HEALTH STATUS CHANGES AND MEDICATION SIDE EFFECTS since last medication appointment. Check all that apply (Click on box).

☐Activity level +/ - ☐Appetite + /- ☐Bruising ☐Constipation ☐Confusion ☐Diarrhea ☐Dizziness	☐Drooling ☐ Drowsiness ☐Dry mouth ☐Falls ☐Fever ☐Homicidal ideation/ behavior ☐Incontinence ☐Lethargy	☐Mental status deterioration ☐Muscle stiffness ☐Nausea/vomiting ☐Pain ☐Painful skin rash/ blisters ☐Seizures ☐Sleep changes +/-	☐Substance use- Alcohol ☐Substance use-Nicotine ☐Substance use-Illicit drugs ☐Suicidal ideation/ behavior ☐Swelling ☐Thirst	☐Tremor ☐Restlessness/inability to remain still ☐Weight changes + / - ☐Worsening of psychiatric symptoms ☐ Other _____ _____

CURRENT PSYCHOSOCIAL STRESSORS within the last six months. Check all that apply (Click on box). Include stressors that continue to affect the person even if the initial onset of the stressor was prior to 6 months ago.

☐	Abuse	☐	Health problems	☐	Pain/infection as a cause of behavior
☐	Educational problems	☐	Housing problems	☐	Parenting stress
☐	Occupational problems	☐	Financial problems	☐	Problems with primary support group
☐	Legal problems	☐	Grief/Loss/Separation	☐	Problems related to social environment
		☐	Issues with sexuality/ relationships	☐	Psychological trauma/Anniversary of trauma
					Other _____

Person's Name_____ Date of Birth:_____ Appointment Date:___

FREQUENCY OF TARGET BEHAVIORS over last 6 months:

Target Behaviors-Residential						

Target Behaviors-Day						

Describe target behaviors:

Check all incidents related to the person's mental health diagnosis or target behaviors since the last medication appointment and describe below: (Click on box).

☐ ER/CPEP Visits ☐ Psychiatric Hospitalization ☐ Police ☐ Physical Restraints ☐ Property Damage ☐ Suicide Threats

Describe incidents:

DAILY FUNCTIONING

Rate the person's participation in the following daily activities since the last medication appointment (Click on box).

Relating to Others				
1. Shows interest in socializing with others	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
2. Gets along with people he/she does not know well	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
3. Gets along with people who are close to him/her	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Life Activities				
4. Helps with household work	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
5. Is cooperative in work or day activities	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
6. Participates in activities or interventions to learn new skills	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
7. Adheres to a daily schedule (with or without assistance)	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Health and Safety				
8. Performs or cooperates with all self-care (e.g., eating, bathing)	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
9. Takes medications as directed	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
10. Maintains regular sleep patterns	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
11. Avoids dangerous situations	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Coping				
12. Manages strong emotions	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
13. Works cooperatively with others at home	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
14. Accepts help when it is needed	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Leisure and recreation				
15. Transitions easily from one activity to the next	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
16. Helps plan community activities for leisure or recreation	☐Usually or Often	☐Sometimes	☐Never	☐Not Able
Comments:				

Summary Completed By: (Signatures indicate that BEHAVIOR DATA AND PRIOR QUARTERLY REPORTS were reviewed in preparing this report.)

Printed Name/ Signature:	**Role:**
Printed Name/ Signature:	**Role:**
Date reviewed with team:	**Date reviewed with prescribing physician:**

Person's Name_____ Date of Birth:_____ Appointment Date:___

PSYCHOTROPIC MEDICATION REVIEW FORM
PHYSICIAN REPORT

(This page to be completed by prescriber of psychotropic medication)

This page can be completed for any appointment but MUST BE COMPLETED EVERY 90 DAYS MINIMUM

Psychiatric Diagnosis and Treatment Plan:

Treatment outcomes over past year: ☐ Unknown ☐Improved ☐No Change ☐Worse

Risks and benefits of current treatment:

Risks:	**Benefits:**

Is this risk present?	No	Yes	Provide rationale for continuing medication if risk is present	Date medication education provided
Off-label use?	☐	☐		
Black box warning issued?	☐	☐		
Medication side effects are observed?	☐	☐		
Symptoms of TD or other EPS are observed?	☐	☐		
Drug interactions are present?	☐	☐		
Medical contraindications are present (e.g. dementia-related psychosis?)	☐	☐		
Medication dosage is outside usual range?	☐	☐		
More than one medication from same drug class?	☐	☐		
Long term use of benzodiazepines?	☐	☐		

Gradual Dose Reduction: Has a gradual dose reduction been attempted in the last 3 months? ☐ YES ☐NO

If YES, outcome of the gradual dose reduction:_____

Is a gradual dose reduction appropriate at this time?

☐ **YES**, gradual dose reduction is appropriate at this time:

☐Recommended dose reduction (write new orders):

_____

☐**NO**, a gradual dose reduction is NOT appropriate at this time?

Reduction is NOT appropriate at this time due to: (check all that apply)

☐Previous attempt at reduction resulted in reoccurrence of behavioral symptoms (documented date: _____)

☐Reduction would likely impair this person's functioning or increase their distressed behavior:

☐Person continues to exhibit interfering target symptoms

☐Person is prescribed lowest effective dose necessary for stabilization

Clinical explanation for when a gradual dose reduction will be considered (e.g., what changes in behavior, mood, thought or functioning are evidence for gradual dose reduction?) _____

SIGNATURE INDICATES REVIEW OF ALL PAGES OF PSYCHOTROPIC MEDICATION REVIEW FORM AND PARTICIPATION IN PSYCHOTROPIC MEDICATION REVIEW MEETING			
Printed Name/Signature	**Date**	**Printed Name/ Signature**	**Date**
Prescriber:		**BSP Clinician:**	
Provider Nurse:		**Person:**	
QIDP:		**Other:**	