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|  |  |
| --- | --- |
| **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** |
|  |  |  |  |  |  |  |
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**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.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| [ ] [ ] [ ] [ ]  | AbuseEducational problemsOccupational problemsLegal problems | [ ] [ ] [ ] [ ] [ ]  | Health problems Housing problemsFinancial problemsGrief/Loss/SeparationIssues with sexuality/ relationships | [ ] [ ] [ ] [ ] [ ]  | Pain/infection as a cause of behaviorParenting stressProblems with primary support groupProblems related to social environmentPsychological trauma/Anniversary of trauma Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **FREQUENCY OF TARGET BEHAVIORS over last 6 months:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  **Target Behaviors-Residential**   |   |  |  |  |  |  |
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| --- | --- | --- | --- | --- | --- | --- |
| **Target Behaviors-Day**  |   |  |  |  |  |  |
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**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).**

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

**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:** |

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