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

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| **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).**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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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 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?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **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:** |  |