

**BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION  
PART ONE: HEALTH SERVICES REPORT**

(To be completed by agency/residential staff (e.g. nurse, program specialist) prior to psychotropic medication)

<b>INDIVIDUAL:</b>		<b>DATE-PSYCHOTROPIC MED REVIEW:</b>	
<b>ADDRESS:</b>		<b>PREVIOUS REVIEW:</b>	
<b>DATE OF BIRTH:</b>		<b>PHYSICIAN'S NAME:</b>	
<b>CARECO CONTACT:</b>		<b>OFFICE ADDRESS:</b>	
<b>CONTACT PHONE:</b>		<b>OFFICE PHONE:</b>	
<b>CURRENT MEDICATIONS</b> <i>(Please list all medications, including over-the-counter, dietary supplements, etc. Attach additional pages if necessary. Include the individual's name and date of review on every page.)</i>			
<b>MEDICATION NAME</b>	<b>DOSAGE</b>	<b>FREQUENCY</b>	<b>Reason for Administration</b>
<b>ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS?</b> <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <i>If "YES," Specify and describe all symptoms:</i>			
<b>HAS THIS DIAGNOSIS CHANGED? SEE PAGE 3 and check if updated:</b>	<b>DIAGNOSIS</b> <i>(5-Axis Diagnosis from a physician, as documented in medical records)</i>	<b>TARGET SYMPTOMS</b> <i>(BEHAVIORAL DESCRIPTION) Target Symptoms listed here must match those listed on Part 2</i>	
<b>AXIS IV</b> <i>(Psychosocial Stressors): as documented by physician/medical records. Notify physician if new issues/changes. Check all that apply:</i>			
<ul style="list-style-type: none"> <li>● Problem with primary support group <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> Housing problems <input type="checkbox"/></li> <li><input type="checkbox"/> Problems related to the social environment <input type="checkbox"/> Occupational problems <input type="checkbox"/></li> <li><input type="checkbox"/> Educational problems <input type="checkbox"/> Economic problems <input type="checkbox"/></li> <li><input type="checkbox"/> Other psychosocial/environmental problems <input type="checkbox"/> Problems related to the judicial system <input type="checkbox"/></li> </ul>			
<b>AXIS V</b> <i>(Global Assessment of Functioning/GAF) Score (0-100) _____ (Score provided by physician per DSM scale)</i>			
<b>Last Tardive Dyskinesia Screening</b> (e.g. AIMS test):		<b>date and result – required every 6 months)</b>	
(Include Score: _____ Date _____)			
<b>CURRENT HEALTH STATUS/MEDICAL ISSUES OF NOTE</b> <i>(Attach significant lab and diagnostic study results): CHECK all items that were an issue since the last psychotropic medication review. Add comments whenever possible.</i>			
<input checked="" type="checkbox"/> appetite +/- <input checked="" type="checkbox"/> constipation <input checked="" type="checkbox"/> dry mouth <input type="checkbox"/> nausea/vomiting <input checked="" type="checkbox"/> swelling <input checked="" type="checkbox"/> alcohol use <input checked="" type="checkbox"/> bruising <input checked="" type="checkbox"/> cough <input checked="" type="checkbox"/> incontinence <input checked="" type="checkbox"/> seizures <input checked="" type="checkbox"/> weight +/- <input checked="" type="checkbox"/> nicotine use <input checked="" type="checkbox"/> congestion <input checked="" type="checkbox"/> diarrhea <input checked="" type="checkbox"/> menstrual change <input checked="" type="checkbox"/> thirst <input checked="" type="checkbox"/> pain <input type="checkbox"/> caffeine use <input checked="" type="checkbox"/> other drug use			
<b>COMMENTS OR SYMPTOMS NOT INCLUDED IN ABOVE LIST:</b> <i>(Please describe)</i>			
<b>Printed name and signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report.</b>			
<b>Completed by:</b> <i>(Printed Name and Signature):</i>		<b>Title:</b>	<b>Date Signed:</b>
<b>Agency Nurse Review:</b> <i>(Printed Name &amp; Signature):</i>		<b>Title:</b>	<b>Date Signed:</b>





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

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

<b>INDIVIDUAL:</b>			
<b>DATE OF PRESENT PSYCH MED REVIEW:</b>		<b>DATE OF NEXT PSYCH MED REVIEW:</b>	
<b>PHYSICIAN'S AGREEMENT WITH CURRENT DIAGNOSES AND TARGET SYMPTOMS:</b> (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: <i>Health Services Report</i> and Part 2: <i>Behavior Support Treatment Report</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No If <b>NO</b> , please change to:			
<b>TREATMENT GOALS</b> (Regarding Target Symptoms listed on Parts 1 and 2):		<b>PROGRESS TOWARD GOALS:</b>	
<input type="checkbox"/> Psychotropic medications are necessary?		<input type="checkbox"/> Yes	
<input type="checkbox"/> Psychotropic medication dosages are within usual range?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Number of drugs conforms to accepted standards? No		<input type="checkbox"/> Yes <input type="checkbox"/>	
<input type="checkbox"/> Are medication side-effects present? (i.e., sedation, ataxia, dyscrasia)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Screening test performed ( i.e., AIMS)? No		<input type="checkbox"/> Yes <input type="checkbox"/>	
<input type="checkbox"/> Symptoms of T.D. or other E.P.S.?		<input type="checkbox"/> Yes	
<input type="checkbox"/> Medication reduction/titration plan considered?		<input type="checkbox"/> Yes	
<b>PHYSICIAN'S ORDERS</b>			
<b>MEDICATION CHANGE:</b> <input type="checkbox"/> NO <input type="checkbox"/> YES (provide information below)			
<b>NEW MEDICATION</b> (List medication, dosage & frequency)			<b>REASON FOR NEW MEDICATION</b>
<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Medication Education Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>
1)			
2)			
3)			
<b>MEDICATION CHANGE</b> (List med, dosage & frequency)			<b>REASON FOR MEDICATION CHANGE</b>
<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Medication Education Provided?</b>
1)			
2)			
3)			
<b>MEDICATION DISCONTINUED</b> (List med dose, frequency)			<b>REASON FOR MEDICATION DISCONTINUATION</b>
<b>Medication</b>	<b>Dosage</b>	<b>Frequency</b>	<b>Medication Education Provided? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>
1)			
2)			
3)			
<b>LAB STUDIES, DIAGNOSTIC TESTS AND FREQUENCIES:</b> Metabolic screening done? <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____			
<b>COMMENTS/CHANGES/REASONS/AREAS OF CONCERN:</b>			
<i>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.</i>			
<b>Physician's Printed Name, Signature and Date:</b>		<b>Clinician: Signature, Title and Date:</b>	
<b>Individual's Consent for Psychotropic Medication: Signature and Date:</b>			
<b>Medical Decision-Maker's consent: Signature and Date:</b>			

