

**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)

INDIVIDUAL:		DATE-PSYCHOTROPIC MED REVIEW:	
ADDRESS:		PREVIOUS REVIEW:	
DATE OF BIRTH:		PHYSICIAN'S NAME:	
CARECO CONTACT:		OFFICE ADDRESS:	
CONTACT PHONE:		OFFICE PHONE:	
CURRENT MEDICATIONS (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.)			
MEDICATION NAME	DOSAGE	FREQUENCY	Reason for Administration
ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS? <input type="checkbox"/> NO <input type="checkbox"/> YES If "YES," Specify and describe all symptoms:			
HAS THIS DIAGNOSIS CHANGED? SEE PAGE 3 and check if updated:	DIAGNOSIS (5-Axis Diagnosis from a physician, as documented in medical records)	TARGET SYMPTOMS (BEHAVIORAL DESCRIPTION) Target Symptoms listed here must match those listed on Part 2	
AXIS I (MH Diagnosis)			
AXIS I (2)			
AXIS II (MR Diagnosis)			
AXIS II (Personality Disorder)			
AXIS III (All Medical Diagnoses)			
AXIS IV (Psychosocial Stressors): as documented by physician/medical records. Notify physician if new issues/changes. Check all that apply: <input type="checkbox"/> Problem with primary support group <input type="checkbox"/> Problems with access to health care services <input type="checkbox"/> Housing problems <input type="checkbox"/> Problems related to the social environment <input type="checkbox"/> Occupational problems <input type="checkbox"/> Educational problems <input type="checkbox"/> Economic problems <input type="checkbox"/> Other psychosocial/environmental problems <input type="checkbox"/> Problems related to the judicial system			
AXIS V (Global Assessment of Functioning/GAF) Score (0-100) _____ (Score provided by physician per DSM scale)			
Last Tardive Dyskinesia Screening (e.g. AIMS test): (Include Score: Date		date and result – required every 6 months)	
CURRENT HEALTH STATUS/MEDICAL ISSUES OF NOTE (Attach significant lab and diagnostic study results): CHECK all items that were an issue since the last psychotropic medication review. Add comments whenever possible. <input type="checkbox"/> appetite +/- <input type="checkbox"/> constipation <input type="checkbox"/> dry mouth <input type="checkbox"/> nausea/vomiting <input type="checkbox"/> swelling <input type="checkbox"/> alcohol use <input type="checkbox"/> bruising <input type="checkbox"/> cough <input type="checkbox"/> incontinence <input type="checkbox"/> seizures <input type="checkbox"/> weight +/- <input type="checkbox"/> nicotine use <input type="checkbox"/> congestion <input type="checkbox"/> diarrhea <input type="checkbox"/> menstrual change <input type="checkbox"/> thirst <input type="checkbox"/> pain <input type="checkbox"/> caffeine use COMMENTS OR SYMPTOMS NOT INCLUDED IN ABOVE LIST: (Please describe) <input type="checkbox"/> other drug use			
Printed name and signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report.			
Completed by: (Printed Name and Signature):		Title:	Date Signed:
Agency Nurse Review: (Printed Name & Signature):		Title:	Date Signed:



**BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION
PART TWO: BEHAVIOR SUPPORT TREATMENT REPORT**

(To be completed by monitoring team member [behavior specialist, QMRP, program specialist, family member] prior to review.)

INDIVIDUAL:	DATE-PSYCHOTROPIC MED REVIEW:													
TARGET SYMPTOMS BEING DOCUMENTED														
<p><i>Include BEHAVIORAL DESCRIPTIONS of Target Symptoms for each mental health diagnosis listed on Axis1 on Part 1 of this form. Behavioral descriptions must be specific to the individual. For each target symptom, fill in the number of occurrences for the past month. Additional charts/graphs may be attached. Add comments wherever possible.</i></p>														
Target Symptoms (from Part 1) BEHAVIORAL DESCRIPTION	Month's Data <i>Fill in frequency of each symptom</i> Wk1 Wk2 Wk3 Wk4	Comments												
1)														
2)														
3)														
4)														
5)														
ADDITIONAL CONCERNS SINCE LAST REVIEW														
<p>Check any symptoms or environmental changes <i>not being documented above</i> that have appeared since the last review (clarify in Additional Comments section below)</p>														
<table style="width:100%; border:none;"> <tr> <td><input type="checkbox"/> Activity Level (increased or decreased)</td> <td><input type="checkbox"/> Obsessive-Compulsive Behavior</td> <td><input type="checkbox"/> Unusual Body Movements (i.e., tremors)</td> </tr> <tr> <td><input type="checkbox"/> Anxiety</td> <td><input type="checkbox"/> Sleep Changes</td> <td><input type="checkbox"/> Other (Specify: _____)</td> </tr> <tr> <td><input type="checkbox"/> Appetite (Increased or decreased)</td> <td><input type="checkbox"/> Suicidal Ideation/Behavior</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td><input type="checkbox"/> Change in Mood</td> <td><input type="checkbox"/> Environmental Issues</td> <td><input type="checkbox"/> Psychotic Symptoms</td> </tr> </table>			<input type="checkbox"/> Activity Level (increased or decreased)	<input type="checkbox"/> Obsessive-Compulsive Behavior	<input type="checkbox"/> Unusual Body Movements (i.e., tremors)	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sleep Changes	<input type="checkbox"/> Other (Specify: _____)	<input type="checkbox"/> Appetite (Increased or decreased)	<input type="checkbox"/> Suicidal Ideation/Behavior	<input type="checkbox"/> None	<input type="checkbox"/> Change in Mood	<input type="checkbox"/> Environmental Issues	<input type="checkbox"/> Psychotic Symptoms
<input type="checkbox"/> Activity Level (increased or decreased)	<input type="checkbox"/> Obsessive-Compulsive Behavior	<input type="checkbox"/> Unusual Body Movements (i.e., tremors)												
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Sleep Changes	<input type="checkbox"/> Other (Specify: _____)												
<input type="checkbox"/> Appetite (Increased or decreased)	<input type="checkbox"/> Suicidal Ideation/Behavior	<input type="checkbox"/> None												
<input type="checkbox"/> Change in Mood	<input type="checkbox"/> Environmental Issues	<input type="checkbox"/> Psychotic Symptoms												
<p><i>Were there any incidents related to the individual's behavioral health diagnosis or target symptoms? Check the box if so, and insert number of occurrences.</i></p>														
<input type="checkbox"/> ER visits?	<input type="checkbox"/> Psychiatric Hospitalizations?	<input type="checkbox"/> Restraints?												
ADDITIONAL COMMENTS														
<p>Signature(s) indicate that prior psychotropic medication review reports were reviewed in preparing this report. This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 30 DAYS MINIMUM.</p>														
SUMMARY COMPLETED BY:	Date form completed:													
Name:														
Role:	Date reviewed with team:													
Signature:	Date reviewed w/prescribing physician:													



BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

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

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

