BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

PART ONE: HEALTH SERVICES REPORT

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

INDIVIDUAL:		**DATE-PSYCHOTROPIC MED REVIEW:**
ADDRESS:		**PREVIOUS REVIEW:**
DATE OF BIRTH:		**PHYSICIAN'S NAME:**
AGENCY NAME:		**OFFICE ADDRESS:**
AGENCY PHONE #:	**AGENCY CONTACT PERSON:**	**OFFICE PHONE #:**

CURRENT MEDICATIONS: ***Please attach current medication list or most recent MAR to this form.***

ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS? ☐No ☐Yes

If **"yes"**, Specify and describe all symptoms:

HAS THIS PSYCHIATRIC DIAGNOSIS CHANGED? SEE PAGE 3 and check if updated: ☐	**DIAGNOSIS**	**SYMPTOMS OF PSYCHIATRIC DIAGNOSIS** ***Symptoms listed here must be provided by the psychiatrist or other prescribing physician and match those listed on Part 2***
Current Psychiatric Diagnoses		
Level of Intellectual Disability		
Physical Health Diagnoses ***(Include all. Attach additional pages if needed)***		

Psychosocial Stressors: Check all that apply:

☐Problem with primary support group	☐Problems with access to behavioral health care services	☐Housing problems
☐Problems related to the social environment	☐Occupational problems	☐Economic problems
☐Educational problems	☐Problems related to interaction with the legal system/crime	☐Other psychosocial and environmental problems

WHODAS *Score (0-100)* _____ (***Score provided by physician per DSM 5 scale, updated annually)*** ***DATE COMPLETED:*** _____

LAST TARDIVE DYSKINESIA SCREENING *(e.g. AIMS test)*: *(Include date and result--**required every 6 months**)*

SCORE: _____ ***DATE:*** _____ ***N/A:*** _____

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 below whenever possible.*

☐appetite **+ / -**	☐constipation	☐dry mouth	☐nausea/vomiting	☐swelling	☐ alcohol use
☐bruising	☐cough	☐incontinence	☐seizures	☐weight **+ / -**	☐ nicotine use
☐congestion	☐diarrhea	☐menstrual change	☐thirst	☐pain	☐ caffeine use
					☐ other drug use

COMMENTS OR MEDICAL HEALTH SYMPTOMS NOT INCLUDED IN ABOVE LIST: *(Please describe)*

Printed** name **and** signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report. **This form can be completed for all psychiatric appointments but psychotropic medication reviews must be completed at least every 90 days.

Completed by: *(Print Name):*	**Title:**	**Date Signed:**
Agency Nurse Review: *(Print Name):*	**Title:**	**Date Signed:**

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PART TWO: TREATMENT REPORT AND OUTCOME TRACKING

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

Symptoms of Psychiatric Diagnosis on this page should have been provided by the psychiatrist

INDIVIDUAL:	**DATE OF PSYCHOTROPIC MED REVIEW:**

Person-Centered Recovery Update: (*Ask the person and indicate, in their own words, whether or not the person believes that their current medication is helping? Ask what symptoms of their mental health challenge is the person's medication helping?)*

SYMPTOMS of PSYCHIATRIC DIAGNOSIS BEING DOCUMENTED

*Include **observable descriptions** of symptoms of psychiatric diagnosis for each psychiatric diagnosis listed on Part 1 of this form. Observable descriptions must **be related to the psychiatric diagnosis**. For each symptom, **fill in the number of occurrences for the past 6 months. Symptoms which are addressed MUST be related to the person's psychiatric diagnoses.***

Symptoms of Psychiatric Diagnosis (from Part 1) OBSERVABLE DESCRIPTION (***MUST MATCH** those listed on Part 1*)	**Monthly Data (past 6 months)** Fill in month and frequency of each Psych Symptom						**Comments**
1)							
2)							
3)							
4)							

ADDITIONAL CONCERNS SINCE LAST REVIEW

Check any symptoms or environmental changes *not being documented above* that have appeared since the last review. Clarify below.

☐ Activity Level (increased or decreased)	☐ Obsessive-Compulsive Behavior	☐ Unusual Body Movements (e.g., tremors)
☐ Anxiety	☐ Sleep Changes	☐ Other (Specify):
☐ Appetite (increased or decreased)	☐ Suicidal ideation/behavior	☐ None
☐ Change in Mood	☐ Environmental Issues	☐ Psychotic Symptoms

Were there incidents during this review period that were related to the individual's psychiatric diagnosis? If yes, check the box and fill in the number of incidents:

☐ ER Visits _____ ☐ Psychiatric hospitalizations _____ ☐ Restraints _____

TREATMENT & RECOVERY PROGRESS (provide update since last review)

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 90 DAYS MINIMUM.***

SUMMARY COMPLETED BY: **Name:**	**Date form completed:**
Role:	**Date reviewed with team:**
Signature:	**Date reviewed w/prescribing physician:**

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

INDIVIDUAL:

DATE OF PRESENT PSYCHOTROPIC MED REVIEW:	**DATE OF NEXT PSYCHOTROPIC MED REVIEW:**

PHYSICIAN'S AGREEMENT WITH CURRENT DIAGNOSES AND SYMPTOMS of PSYCHIATRIC DIAGNOSES:
(see Page 1 and Page 2)
Do the diagnosis(es) listed in Part 1 and the presenting psychiatric symptoms in Part 2 remain the same? ☐ **Yes** ☐ **No**
If **NO,** *please change to:*

TREATMENT GOALS (Regarding Symptoms of Psychiatric Diagnosis listed on Parts 1 and 2):	**PROGRESS TOWARD GOALS:**

♦	Psychotropic medications are necessary?	☐**Yes** ☐**No**	
♦	Psychotropic medication dosages are within usual range?	☐**Yes** ☐**No**	
♦	Number of drugs conforms to accepted standards?	☐**Yes** ☐**No**	
♦	Are medication side-effects present? *(e.g. sedation, ataxia, dyscrasia)*	☐**Yes** ☐**No**	
♦	Screening test performed (e.g. AIMS)?	☐**Yes** ☐**No**	
♦	Symptoms of T.D. or other E.P.S.?	☐**Yes** ☐**No**	
♦	Medication reduction plan considered?	☐**Yes** ☐**No**	

PHYSICIAN'S ORDERS

MEDICATION CHANGE: ☐ **No** ☐**Yes** ***(provide information below)***

NEW MEDICATION *(List medication, dosage & frequency)*			**REASON FOR NEW MEDICATION**
Medication	**dosage**	**frequency**	**Medication Education Provided? ☐Yes ☐No**
1)			
2)			
3)			

MEDICATION CHANGE *(List med., dosage & frequency)*			**REASON FOR MEDICATION CHANGE**
Medication	**dosage**	**frequency**	**Medication Education Provided? ☐Yes ☐No**
1)			
2)			
3)			

MEDICATION DISCONTINUED *(List med., dosage & frequency)*			**REASON FOR MEDICATION DISCONTINUATION**
Medication	**dosage**	**frequency**	**Medication Education Provided? ☐Yes ☐No**
1)			
2)			
3)			

LAB STUDIES, DIAGNOSTIC TESTS ORDERED: Metabolic screening done? ☐Yes ☐No Date:_____

COMMENTS/CHANGES/REASONS/AREAS OF CONCERN:

My signature below indicates that I have reviewed the Health Services and Treatment Reports. I have reviewed my recommendations, as well as the consequences to the individual for not following my recommendations with all parties attending this review. ***[This form can be completed for any appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.]***

Physician's Printed Name, Signature and Date:	**Clinician: Signature, Title and Date:**

Consumer's Consent for Psychotropic Medication: Signature and Date:

Accompanying Person's Printed Name, Signature and Date: