

Instructions for Completing the Team Review of Psychotropic Medications

The Team Review of Psychotropic Medication is commonly referred to as the three part form because it consists of three pages. Each page is a separate report.

Information reported in each separate report should be consistently reported in all three reports e. g. target symptoms.

Page One: Part One: Health Services Report

- The Health Services Report is to be completed by assigned residential support staff at an agency or a family member prior to the appointment with the person's psychiatrist.
- The previous Team Review Forms need to be reviewed for accuracy and any changes that need to be made to the current Health Services Report.
- If the person seeing the psychiatrist is supported by an agency with a nurse, the agency nurse needs to also review the current Health Services Report for accuracy and completeness.

Page Two: Part Two: Behavior Support Treatment Report

- The Behavior Support Treatment Report can be completed by anyone, but ideally will be completed by a behavior specialist.
- The previous Team Review Forms need to be reviewed for accuracy and any changes that need to be made to the current Behavior Support Treatment Report.

Page Three: Part Three: Physician's Report

- The Physician's Report can only be completed by the physician prescribing psychotropic medication.
- The Physician's signature indicates that the physician has reviewed the Health Services and Behavior Support Treatment Report.
- If possible the person, for whom the psychotropic medication is being prescribed, should sign the form indicating consent for being treated with psychotropic medication.

Please contact Philadelphia Coordinated Health for additional information/ training on how to complete the Team Review of Psychotropic Medication at 215-546-0300. Thank you.

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 OF PSYCHOTROPIC MED REVIEW:
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LEVEL OF RESTRICTIVENESS PER BEHAVIOR INTERVENTION POLICY**
 LEVEL I LEVEL II LEVEL III NOT APPLICABLE (Not registered with Phila.)
***This is only for individuals funded by Philadelphia County, see Philadelphia Behavior Intervention Policy for details*

TARGET SYMPTOMS BEING DOCUMENTED

Include BEHAVIORAL DESCRIPTIONS of Target Symptoms for each mental health diagnosis listed on Axis I 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 6 months. Additional charts/graphs may be attached. Add comments wherever possible.

Target Symptoms (from Part 1) BEHAVIORAL DESCRIPTION (MUST MATCH those listed on Part 1)	Monthly Data (past 6 months)						Comments
	Fill in month and frequency of each Target Symptom						
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 in Additional Comments section below)

<input type="checkbox"/> Activity Level (increased or decreased)	<input type="checkbox"/> Obsessive-Compulsive Behavior	<input type="checkbox"/> Unusual Body Movements (e.g., 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

Check if there were incidents this review period related to the individual's behavioral health diagnosis or target symptoms, and fill in the number of incidents: ER Visits _____ Psychiatric hospitalizations _____ Restraints _____

ADDITIONAL COMMENTS

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:	Date form completed:
Name:	Date reviewed with team:
Role:	Date reviewed w/prescribing physician:
Signature:	

BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

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

