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: **BSU #:**	**PHYSICIAN'S NAME:**
AGENCY CONTACT:	**OFFICE ADDRESS:**
AGENCY PHONE #:	**OFFICE PHONE #:**

CURRENT MEDICATIONS *(Please list all medications--including OTC medications, dietary supplements, etc. Attach additional pages if necessary. Include individual's name and date of review on every page.)*

MEDICATION NAME	DOSAGE	FREQUENCY	*Reason for Administration*

ARE THERE ALLERGIES OR CONTRA-INDICATED MEDICATIONS? ☐No ☐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 Diagnois)***		
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:**

☐ Problem with primary support group ☐ Problems with access to 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

Axis V *(Global Assessment of Functioning/GAF)* ***Score (0-100)*** _____ (***Score provided by physician per DSM scale, updated annually***)

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 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 any appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.***

Completed by: *(Printed Name and Signature):*	Title:	Date Signed:
Agency Nurse Review: *(Printed Name & Signature):*	Title:	Date Signed:

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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:**

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)** Fill in month and frequency of each Target 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 in Additional Comments section 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

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: 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 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: *Health Services Report* and Part 2: *Behavior Support Treatment Report*? ☐ Yes ☐ No If NO, *please change to:*

TREATMENT GOALS (Regarding Target Symptoms 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 AND FREQUENCIES: Metabolic screening done? ☐Yes ☐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: