## BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION PART ONE: HEALTH SERVICES REPORT bleted by agency/residential personnel, e.g. nurse, program specialist, family member, prior to psychotropic medication

|  | ency/residential personnel, e.g. nurse, pro                                   | ogram specialist, family member, prior to ps                              |   |  |  |  |  |
|--|---|---|---|--|--|--|--|
| INDIVIDUAL:  |   |   | DATE-PSYCHOTROPIC MED REVIEW:                                 |  |  |  |  |
| ADDRESS:   |   | PREVIOUS REVIEW:  |   |  |  |  |  |
| DATE OF BIRTH:   | BSU #:  | PHYSICIAN'S NAME:   | PHYSICIAN'S NAME:   |  |  |  |  |
| AGENCY CONTACT:  |   | OFFICE ADDRESS:   | OFFICE ADDRESS:   |  |  |  |  |
| AGENCY PHONE #:  |   | OFFICE PHONE #:   | OFFICE PHONE #:   |  |  |  |  |
|  |   | including OTC medications, dietary supplen                                | nents, etc. Attach additional                                 |  |  |  |  |
| pages if necessary. Include<br>MEDICATION NAME   | individual's name and date of review  |   |   |  |  |  |  |
|  | DOSAGE FREQUE   | Reason for  | Administration  |  |  |  |  |
|  |   |   |   |  |  |  |  |
|  |   |   |   |  |  |  |  |
|  |   |   |   |  |  |  |  |
|  |   |   |   |  |  |  |  |
|  | ES OR CONTRA-INDICATED ME   |   |   |  |  |  |  |
| If "Yes", Specify and describe   |   | DICATIONS? No Yes   |   |  |  |  |  |
| HAS THIS DIAGNOSIS   |   |   | DEMANDAL DESCRIPTION  |  |  |  |  |
| CHANGED? SEE PAGE 3  | <b>DIAGNOSIS</b> (5-Axis Diagnosis j<br>physician, as documented in medical r |   | (BEHAVIORAL DESCRIPTION)<br>sust match those listed on Part 2 |  |  |  |  |
| and check if updated:<br>AXIS I  |   |   |   |  |  |  |  |
| (MH Diagnosis)   |   |   |   |  |  |  |  |
| AXIS I (2)   |   |   |   |  |  |  |  |
| - ( )  |   |   |   |  |  |  |  |
| AXIS II  |   |   |   |  |  |  |  |
| (MR Diagnois)  |   |   |   |  |  |  |  |
| AXIS II (Personality<br>Disorder)  |   |   |   |  |  |  |  |
| AXIS III   |   |   |   |  |  |  |  |
| (All Medical Diagnoses)  |   |   |   |  |  |  |  |
|  |   | cal records. Notify physician if new issues/                              |   |  |  |  |  |
| Problem with primary sup   |   |   | g problems  |  |  |  |  |
| Problems related to the social environment     Occupational problems     Economic problems     Occupational problems     Occupational problems     Occupational problems     Occupational problems     Occupational problems     Occupational problems |   |   |   |  |  |  |  |
| Educational problems   | system/crime  | I to interaction with the legal Other p<br>problems                       | sychosocial and environmental                                 |  |  |  |  |
| Axis V (Global Assessment of Functioning/GAF) Score (0-100) (Score provided by physician per DSM scale, <u>updated annually</u>  |   |   |   |  |  |  |  |
| LAST TARDIVE DYSKINESIA SCREENING (e.g. AIMS test): (Include date and resultrequired every 6 months)   |   |   |   |  |  |  |  |
| SCORE: DATE: N/A:  |   |   |   |  |  |  |  |
|  |   | <b>OF NOTE</b> (Attach significant lab and diag                           |   |  |  |  |  |
| <b>CHECK</b> all items that wer<br>appetite + / -  | e an issue since the last psychotropic  | medication review. Add comments bel                                       |   |  |  |  |  |
|  |   |   | •   |  |  |  |  |
|  | diarrhea menstrual cha  |   |   |  |  |  |  |
|  | TOMS NOT INCLUDED IN ABO  |   | other drug use  |  |  |  |  |
| <b>Printed</b> name <b>and</b> signature(s) indicating prior psychotropic medication review reports were reviewed in preparing this report. <b>This</b>  |   |   |   |  |  |  |  |
|  |   | nedication review reports were reviewed<br>medications MUST BE REVIEWED I |   |  |  |  |  |
| Completed by: (Printed Nam   |   |   | Date Signed:  |  |  |  |  |
|  | <i>,</i>  |   | J.  |  |  |  |  |
| Agency Nurse Review: (Pri  | ntod Namo & Signatura),   | itle:   | Date Signed:  |  |  |  |  |
| Ayency Nulse Review: (PII  | πτα ιναπτ α σιγπαιατέ).   |   | Date Signeu.  |  |  |  |  |
|  |   |   |   |  |  |  |  |

## 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 C      | )F PS\    | (СНОТ     | ROPIC              | ; MED     | REVIEW:  |  |
|---|---------------------------------|-----------|-------------|-----------|-----------|--------------------|-----------|--|--|
|   | _                               |           |             |           |           |                    |           |  |  |
| **This is only for individuals funded l   | <b>VEL II</b> [<br>by Philadelp |           |             |           |           |                    |           | (Not registered with Phila.)<br>fon 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 <b>specific to the individual</b> . For each target symptom, <b>fill in the number of</b> occurrences for the past 6 months. Additional charts/graphs may be attached. Add comments wherever possible.  |                                 |           |             |           |           |                    |           |  |  |
| Target Symptoms (from   | Part 1)                         | ſ         | Monthly     | / Data (  | past 6 r  | months             | ;)        |  |  |
| BEHAVIORAL DESCRIP<br>(MUST MATCH those listed on   | -                               | Fill in m | nonth and   | frequenc  | y of each | Target S           | ymptom    | Comments   |  |
| 1)  | (Fail I)                        | _         |             |           |           |                    |           |  |  |
| ')<br>  |                                 |           |             |           |           |                    |           |  |  |
| 2)  |                                 |           |             |           |           | ļ                  |           |  |  |
| <i></i>   |                                 |           |             |           |           |                    |           |  |  |
| 3)  |                                 |           |             |           |           |                    |           |  |  |
| 3)  |                                 |           |             |           |           |                    |           |  |  |
| 4)  |                                 |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
| AI<br>Check any symptoms or environment   | DDITION                         |           |             |           |           |                    |           |  |  |
|   |                                 | Ċc        | omments s   | section b | elow)     | c appoor           |           |  |  |
| Activity Level (increased or decrease   | ·                               |           | /e-Compul   | Isive Beh | avior     | l                  |           | ual Body Movements (e.g., tremors)                     |  |
| Anxiety   |                                 | Sleep Ch  | U           |           |           | l                  |           | r (Specify):   |  |
| Appetite (increased or decreased)   |                                 |           | ideation/be |           |           | l                  | None      |  |  |
| Change in Mood  |                                 | Environn  | mental Issu | ues       |           | 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:         Image: Description of the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the number of incidents:         Image: Description of the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the number of incidents:         Image: Description of the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide the provide the individual's behavioral health diagnosis or target symptoms, and fill in the provide thealthealthealthealthealthealthealtheal |                                 |           |             |           |           |                    |           |  |  |
|   | ADDITIONAL COMMENTS             |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
| Signature(s) indicate that prior psy  | chotropic r                     | medicati  | ion revie   | w repor   | ts were   | reviewe            | ed in pre | eparing this report. This form can                     |  |
| be completed for any appointme  |                                 |           |             |           | UST BE    | REVIE              | WED E     |  |  |
| <u>SUMMARY COMPLETED BY</u> :<br>Name:  |                                 |           |             |           | Date for  | m compl            | eted:     |  |  |
| Role:   |                                 |           |             |           | Date rev  | viewed w           | ith team: | •  |  |
|   |                                 |           |             |           |           |                    |           |  |  |
| Signature:  |                                 |           |             |           | Date rev  | viewed w           | /prescrib | bing physician:  |  |

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## BEHAVIORAL HEALTH: TEAM REVIEW OF PSYCHOTROPIC MEDICATION

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

| INDIVIDUAL:  |                   |                         |  |  |  |  |  |
|--|-------------------|-------------------------|--|--|--|--|--|
| ATE 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> Yes No If NO, <i>please change to:</i>   |                   |                         |  |  |  |  |  |
| TREATMENT GOALS (Rega<br>Parts 1 and 2):   | arding Target Sym | otoms listed on         | PROGRESS TOWARD GOALS:   |  |  |  |  |
| <ul> <li>Psychotropic medications</li> </ul>   | are necessary?    |                         | □Yes □No   |  |  |  |  |
| <ul> <li>Psychotropic medication d</li> </ul>  |                   | sual range?             | Yes No   |  |  |  |  |
| <ul> <li>Number of drugs conforms</li> </ul>   |                   |                         | □Yes □No   |  |  |  |  |
| Are medication side-effects  | · · ·             | ion, ataxia, dyscrasia) | Yes No   |  |  |  |  |
| <ul> <li>Screening test performed</li> </ul>   | -                 |                         |  |  |  |  |  |
| <ul> <li>Symptoms of T.D. or other</li> </ul>  |                   |                         |  |  |  |  |  |
| Medication reduction plan  | considered?       | 510/6161                | Yes No   |  |  |  |  |
|  |                   |                         | N'S ORDERS   |  |  |  |  |
| MEDICATION CHAN  |                   |                         | (provide information below)  |  |  |  |  |
| NEW MEDICATION (List )<br>Medication   | °                 |                         | REASON FOR NEW MEDICATION<br>Medication Education Provided? Yes No |  |  |  |  |
| 1)   | dosage            | frequency               |  |  |  |  |  |
| 2)   |                   |                         |  |  |  |  |  |
| 3)   |                   |                         |  |  |  |  |  |
| MEDICATION CHANGE  | List med., dosage | & frequency)            | REASON FOR MEDICATION CHANGE                                       |  |  |  |  |
| Medication   | dosage            | frequency               | Medication Education Provided? Yes No                              |  |  |  |  |
| 1)   |                   |                         |  |  |  |  |  |
| 2)   |                   |                         |  |  |  |  |  |
| MEDICATION DISCONTINUE   | D(list med dos    | i<br>age & frequency)   | REASON FOR MEDICATION DISCONTINUATION                              |  |  |  |  |
| Medication   | dosage frequency  |                         | Medication Education Provided? Yes No                              |  |  |  |  |
| 1)   | <b>3</b>          |                         |  |  |  |  |  |
| 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<br>the consequences to the individual for not following my recommendations with all parties attending this review. [This form can be completed for any<br>appointment but psychotropic medications MUST BE REVIEWED EVERY 90 DAYS MINIMUM.] |                   |                         |  |  |  |  |  |
| Physician's Printed Name, Signature and Date:<br>Clinician: Signature, Title and Date:   |                   |                         |  |  |  |  |  |
| Consumer's Consent for Psychotropic Medication: Signature and Date:  |                   |                         |  |  |  |  |  |
| Accompanying Person's Printed Name, Signature and Date:  |                   |                         |  |  |  |  |  |