

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 (<i>MUST MATCH</i> those listed on Part 1)	Monthly Data (past 6 months) <small>Fill in month and frequency of each Target Symptom</small>	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)

<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:
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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:
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- | | | | |
|---|------------------------------|-----------------------------|--|
| ◆ 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: No Yes (provide information below)

<i>NEW MEDICATION (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)			

<i>MEDICATION CHANGE (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)			

<i>MEDICATION DISCONTINUED (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? 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:
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Consumer's Consent for Psychotropic Medication: Signature and Date:

Accompanying Person's Printed Name, Signature and Date: