Circle of Support, Inc.

PSYCHIATRIC EXAMINATION

Name: ________________________________ **Address:** ______________________________________

Please complete the following:

Mental Status Report

____

____

Diagnostic Impression and Diagnosis (DSM IV)

____

____

Current Medication(s):

____

____

Rational for the Use of Medication(s)

____

____

***Are there any side effects observed?** ☐ **Yes** ☐**No If yes, describe:** ______________________________

Has Medication been changed? ☐ **Yes** ☐ **No If yes, specify**_____________________________________

Has Medication been discontinued? ☐ **Yes** ☐ **No If yes, why?**_________________________________

Has the benefits and side effects of the medication(s) been reviewed? ☐ **Yes** ☐**No**

Screening for Tardive Dyskinesia has been completed: ☐ **Yes** ☐ **No**

***PHYSICIAN'S ORDER:**

☐ **Individual to self-administer medication independently.**

☐ **Individual to participate in self-administration of medication training program.**

Recommendations____

____

Next Follow-Up visit date: ____

Please choose one: ☐ **once a month** ☐**once in 2 months** ☐ **once in 3 months** ☐**once in 6 months**

☐ **Other** ______________________ **If needed, explain**____

Psychiatrist' Name (Printed): ____________________________________**Date:**______________________

Psychiatrist' Signature: ____________________________________

Address:_______________________________________ **Telephone:** _______________________________

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