Behavior Modifying Medication Review-Page 1

INSTRUCTIONS: Page 1 should be completed by the service provider prior to each medication review and shared with the prescribing physician. The prescribing physician should complete page 2.

Individual's Name:

Age:_______ Date of Birth: ______ Height: ________ Weight: __________________

Primary Care Physician:

Page 1 Completed by: (Check one: each service provider should submit a separate form)

__________Residential Provider: iCare Family Health Services

__________Day Program: Agency/Setting______________________________________

List all current Behavior Modifying Medications:

Individual's Current Medication	Current Dosage	Start Date	Last Review Date

Results of Treatment Plan (attach graph of target behaviors and describe significant changes in observable behavior).____

____

Changes in the Individual's Environment (i.e., illness, staff turnover, family issues, change in residence, etc.):__________________

____

Comments (include any observed side effects): ____

____

Comments (include any observed side effects): ____

____

Persons in attendance at this Medication Review:

Name	Title

Date of current Consent Form(s):__________Date of Most Recent DISCUS or AIMS:_________Date of Current ISPP Approval: _________

Page 1 completed by:_________________________ Date____________________________________

Behavior Modifying Medication Review-Page 2

Changes in the Treatment Plan:

Medication	New Dosage	Start Date

Reason for medication change: * (The legally responsible party should be notified of all medication changes. If new dosage exceeds the previously established maximum dosage, then a new signed consent-indicating the new maximum dosage must be obtained)

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Behavior(s) expected to be affected:

____

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____

Criteria for medication reduction/increase:

____

____

____

Laboratory test prescribed: ______________________________

Is a TDK screening necessary? ______________________________

Recommendations/Comments: ______________________________

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____

Analysis of the results of the DISCUS or AIMS test (if Applicable): ______________________________

____

Date of next medication review: ______________________________

Signature of Psychiatrist/Prescribing physician: ______________________________

Print name: ______________________________ Date: ______________

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Guardian Notification

Date/time of notification______________/______________

Means of notification (telephone, written correspondence, email. Etc.) ______________

Comments: ______________________________

Names/Title of the person conducting the notification______________

Copies to DDD Case Manager, Residential Program, Day Program

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