FAMILY TOUCH BEHAVIOR MODIFYING MEDICATION REVIEW

This form may be emailed to FamilyTouchReporting@gmail.com

Individual's Name: ______________________ Date of Med Review: ______________

Date of Birth: __________________ Height: __________ Weight: __________

Physician's Name: ____________________________ Attending Provider: ______________

List all Current Behavior Modifying Medications:

Medication	Current Dose	Administration Time(s)	Purpose (same as ISP)

Target Behaviors: ____

BTP Data Since Last Med Review: Date of Last Med Review:

Last 3 Months -->			
Target Behavior Frequency:			
Alternative Behavior Achievement			

Summary of observed / experienced behaviors or side effects since last review:

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Changes in the individual's environment during review period (e.g. illness, staff turnover, changes in residence):

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**********************************TO BE COMPLETED BY PHYSICIAN**********************************

Changes in Medication:**

Medication	New Dose	Instructions

Reason(s) for Medication Change: ______________________________

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Summary / recommendations from the physician (e.g. lab work, special monitoring):

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Follow up Needed: ☐ Yes ☐ No When: __________ Next scheduled Med Review: __________

Physician's Signature: ______________________________ Date: ______________

****Providers: The legally responsible person should be notified of all medication changes. If the new dosage exceeds the previously established maximum dosage, then a new signed consent must be obtained indicating the new maximum dosage. The PRC Chairperson should be notified if the dosage of the medication is increased or if a new behavior modifying medication is introduced.**

Date Guardian notified: ______________________ Date PRC notified: ______________