Medication Treatment Plan

Recipient Information		Provider Information	
Name:		**Name:**	
Guardian Name (if applicable):			
DOB:		**Treatment Plan Date:**	
Frequency of visits with the Provider:			
Other Agencies/Individuals Involved:		**Plan to Coordinate Services:**	
Medication:	**Dose:**	**Frequency:**	**Indication:**
Roger's Monitor? ☐ YES ☐ NO If yes, attach copy.			
Description of baseline behavior (if available):			
Description of behavior to be controlled/modified:			
Medication common risks/side effects:			
Procedures to minimize risks (i.e. clinical monitoring – weights, blood work, etc…):			
Explain how data (clinical monitoring, behavior tracking, etc. . .) will be communicated to provider and how often:			

Objective indicators of target behavior or relevant symptoms prior to intervention with proposed medication (e.g. medication X is prescribed for aggression which is occurring 4x/wk. When behaviors are reduced to 1x/wk, the team will provide this information to the prescribing physician so that he/she may consider next steps such as terminating/fading/reducing the medications)**:**
General clinical plan/course ofr use of medication (plan for re-evaluating/adjusting medication based on treatment data):
Clinical indications for terminating this medication (including success, improvement, significant decrease in the behavior or an increase in behavior for which the medication is intending to reduce):
Participant Signature:
Guardian's Signature (if applicable):
Provider's Signature:
Provider's Name/Title (Print):
Pride, Inc. Nurse Signature: