PSYCHOTROPIC MEDICATION REVIEW

Your patient is currently receiving the following psychotropic medication(s). State rules require that the dose of these medications be reviewed at least every 6 months. The facility must provide behavior updates to help facilitate an informed decision on possible dose reduction or continuing such medications. Please review, complete, sign and fax.

<table>
<thead>
<tr>
<th>Resident Name:</th>
<th>DOB:</th>
<th>Date of request:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant Diagnoses:</td>
<td></td>
<td>Reporting Period:</td>
</tr>
<tr>
<td>Facility:</td>
<td>Phone #</td>
<td>Fax #</td>
</tr>
<tr>
<td>Dr:</td>
<td>Phone #</td>
<td>Fax #</td>
</tr>
</tbody>
</table>

CURRENT MEDICATION ORDER

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose and Frequency</th>
<th>Symptoms Treated</th>
<th>If PRN, # times used in past 6 months</th>
</tr>
</thead>
</table>

BEHAVIOR / SYMPTOM UPDATE

<table>
<thead>
<tr>
<th>Behaviors / Symptoms Observed</th>
<th>How many episodes were observed in last 6 months</th>
<th>Approximately, how long did each episode last</th>
<th>or \uparrow or \downarrow in behavior / symptom</th>
</tr>
</thead>
</table>

MEDICATION SIDE EFFECTS NOTICED

NEW PHYSICIAN ORDER

I have reviewed this resident’s psychotropic medication and corresponding behavioral updates. Resident requires the following:

- [ ] Dose reduction / New prescription
- [ ] Resident is on optimal dose and is clinically stable – Continue the medication as prescribed
- [ ] Past dose reductions caused resident to show increased behaviors – Continue the medication as prescribed

________________________________________
Physician Signature & Date