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.

Resident Name:	**DOB:**	**Date of request:**
Relevant Diagnoses:	**Reporting Period:**	
Facility:	**Phone #**	**Fax #**
Dr:	**Phone #**	**Fax #**

CURRENT MEDICATION ORDER

Medication	Dose and Frequency	Symptoms Treated	If PRN, # times used in past 6 months

BEHAVIOR / SYMPTOM UPDATE

Behaviors / Symptoms Observed	How many episodes were observed in last 6 months	Approximately, how long did each episode last	↑ or ↓ in behavior/ symptom

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