



Semi-annual Psychotropic Medication Review

The service recipient's Team:

- uses this form to review the use of psychotropic medication at least every six months; and
- updates this form when current medication is discontinued or new medication is added with the update date indicated.

a. Identifying information

Service recipient	Case number	Date of birth
Case manager	Area	
Team review dates _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____ ; _____		

b. Diagnosis, medication, and target symptoms/behaviors

DSM IV diagnosis, verify with prescribing physician:

Axis I: _____
 Axis II: _____
 Axis II: _____

Current psychotropic medications				Target symptoms/behaviors
Medication	Dosage	Date started	Reason prescribed, such as aggression, depression, or psychosis	Mental illness symptoms/behaviors medication is prescribed to treat ¹

¹ Note: The Team will collect data on these for the prescribing physician.

Does the Team agree with symptom list for the diagnosis? Yes No
If no, what steps have been or will be taken to address this with the prescribing physician. Indicate what the disagreement is and why.

c. Potential harmful effects of medications

1. What are risks/side effects of the prescribed medications? List risks/side effects that are most frequent or may impact the service recipient.
2. **Polypharmacy review**, if required, **completed on _____ (date)**.
3. **Recommendations** from polypharmacy review team **followed up on:**

d. Monitoring status

1. Data:

Indicate how medication responsive targets in Section b. will be tracked for report to the prescribing physician. Do not use Form 06MP046E, Incident Report, for this purpose. Indicate what will be tracked and by whom. Indicate who will compile and analyze data and report this information to the prescribing physician. Summarize this information on Form 06HM005E, Referral Form for Examination or Treatment, or attach to Form 06HM005E.

2. Psychotropic medication reduction plan:

Specify criteria, such as frequency or severity level of medication responsive symptoms/behaviors that will prompt the Team to request the physician to consider a reduction or increase in medication. For example, if the service recipient has:

- two or fewer aggressive incidents per month for four consecutive months, the Team will ask the physician to consider a reduction in medication; or
- fewer than five episodes of hallucinations in six months, the Team will ask the physician to consider a reduction in medication.

3. Semi-annual review:

This form must be reviewed and updated every six months. Indicate the date of last review and projected date of next review. For an update with no significant changes, include statement that the Team believes other items documented on this form are still accurate.

e. Factors related to medication responsive symptoms/behaviors

1. Stressors/circumstances.

Discuss and identify any environmental or personal stressors/circumstances that may trigger symptoms/behaviors.²

2. Approaches.

Describe less restrictive approaches or other approaches utilized in the past to treat mental illness symptoms, resolve behavior challenges, or both.²

3. Data summary.

Provide a data summary indicating frequency, severity, or both over the last six months, of symptoms/behaviors targeted by the medication.²

Routing:

Original - file in Client Contact Manager (CCM) by date

Copy - attach with any plan directed to Statewide Behavior Review Committee (SBRC) for review

² **Note:** If this form accompanies the service recipient's Protective Intervention Plan (PIP) and information for a particular item may be found in the PIP, simply refer to it. For example, see Section III-A in PIP.