Psychotropic Medication Review

Consultant Pharmacist's Medication Regimen Review
Includes the following classification: **Psychotropic Medication Review**

Care Center: **Cottages** Fax: Review Date: Reporting Period:

Resident:	Date of Birth:
Provider:	Fax number:

Your patient is currently receiving the following psychotropic medication(s). State regulations 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 gradual dose reductions or clinical rationale for continuing such medications. Please review, complete, sign, and fax.

Current Psychotropic Medication Order(s)

Behavior/Symptom Update

Behaviors/Symptoms Observed	Number of episodes observed in last 6 months	Length of time each episode lasted	Increase or decrease in behaviors or symptoms

Noted Medication Side Effects

Prescriber's Response:

☐ **Please implement the following dose reduction(s):** _____

_____

☐ **Past dose reductions resulted in increased behaviors and significant clinical decompensation in the patient's wellbeing. A dose change is contraindicated.**

Specific clinical rationale: _____

☐ **Resident is on optimal dose and is clinically stable. Continue the medication as prescribed.**

Provider's Signature: _____ **Date:** _____