PATHWAY HEALTH
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Psychotropic Medication Assessment

Date: _____________
Type of Assessment: ❑ **Initiation of new medication** ❑ **Annual or quarterly review** ❑ **Condition change**
Current ADL Function for most ADL's: ❑ Independent ❑ Assist of 1 ❑ Assist of 2 or more ❑ Dependent
Diagnoses and Medical Conditions (List):

_______________________________ _______________________________ _______________________________

_______________________________ _______________________________ _______________________________

Target behavior(s) present: ❑ Physically Abusive ❑ Verbally Abusive ❑ Resistive to Cares ❑ Wandering
❑ Eating Disturbances ❑ Delusional ❑Hallucinations ❑ Crying ❑Repetitive Verbalizations ❑ Self-Injury
❑ Sexually Inappropriate ❑ Withdrawn ❑ Sleep Cycle Issues ❑ Property Destruction ❑ Sad Mood ❑ Anxious
❑ Other (Describe): ____
Onset: ___________________ Frequency: ___________ Precipitating Factors: _______________________________

Classification	Medication(s)	Dosages/Frequency	Dates: 1. = Start date 2. = GDR Gradual dose reduction date
❑ **Antidepressant**			1.___/___/___ 2. __/___/___
Dx:			1.___/___/___ 2. __/___/___
❑ **Anti-anxiety**			1.___/___/___ 2. __/___/___
Dx:			1.___/___/___ 2. __/___/___
❑ **Antipsychotic**			1.___/___/___ 2. __/___/___
Dx:			1.___/___/___ 2. __/___/___
❑ **Hypnotic**			1.___/___/___ 2. __/___/___
Dx: ❑ **Complete Sleep Assessment**			1.___/___/___ 2. __/___/___
❑ **Other**			1.___/___/___ 2. __/___/___

1. **Were PRN psychotropic meds given in past quarter?** NO ❑ YES ❑ If yes, average frequency ___________/Month
2. **If PRN ordered, reason for use:** ____
3. **Do resident behaviors cause the resident to present danger to themselves or others or interfere with staff's ability to provide cares?** YES ❑ NO ❑ Describe Details: ____
4. **Do current or historical psychotic symptoms (Hallucinations, paranoia, delusions etc...) cause impairment in functional capacity?** Describe Details: ____
5. **Review the target behavior/mood/sleep monitoring. What trends or precipitating factors are noted?**
   Describe: (Time of day, precipitating factors, etc...) ____
   ____
   ____
6. **Check the following items for current concerns or for potential root cause of behaviors/mood/insomnia:**
   ❑ Medication side-effects ❑ New admission/room transfer ❑ Pain ❑ Infection ❑ Acute psychotic illnesses
   ❑ Symptoms of delirium (disorganized thinking, rapid onset, decreased LOC) ❑ Insomnia/sleep deprived
   ❑ Environmental stressors (heat, noise, room, light, etc..): __________ ❑ Fatigue ❑ Depression ❑ Anxiety
   ❑ Substance intoxication or withdrawal ❑ Psychological stressors (i.e., grief, financial) ❑ Boredom ❑ Fear
   ❑ Hunger/thirst/dehydration ❑ Urinary frequency ❑ Constipation ❑ Use of suppositories
   ❑ Neurological diagnosis/stressors (Parkinson's, ALS, Huntington's, CVA): __________________________
   ❑ Caregiver approaches ❑ Overstimulation ❑ Under stimulation ❑ Autonomy/privacy
   ❑ Changes from normal routine ❑ Sensory deficits (hearing, speech, communication, vision) ❑ Abnormal VS
   ❑ Abnormal lab values (electrolyte and metabolic disturbances) ❑ Social stressors (Other residents, activities, etc.)
   ❑ Other: ____

Name: ____ MR#_____________ Room#__________

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7. **Has resident been seen by psychological services in past 90 days?** YES ❑ NO ❑ Name:________________________
8. **Recommendations from psychological services:** ____

____

9. **Non-pharmacological interventions used in past that were not effective:** ____________________________________

____

10. **Non-pharmacological interventions currently used:** ____

____

11. **Tardive Dyskinesia AIMS/Discus completed:** ❑ YES ❑ NO ❑ N/A Date last performed: ___________________
12. **Has gradual dose reduction (GDR) been attempted?** Describe: ____
13. **Resident allergies:** ____
14. **Medications, supplements, herbal products resident is currently taking potentially incompatible with psychotropic medication:**

    _____________________________ _____________________________ _____________________________

    _____________________________ _____________________________ _____________________________

15. **Multiple practitioners ordering psychotropic medications:** ❑ YES ❑ NO If yes, discussed with attending physician: ❑ YES ❑ NO Describe: ____
16. **Has resident in past 90 days exhibited potential medication side-effects:** ❑ Unsteady gait ❑ Frequent falls ❑ Refusing to eat ❑ Weight loss ❑ Difficulty swallowing ❑ Tardive dyskinesia (involuntary movement of muscles) ❑ Dry mouth ❑ Diarrhea ❑ Fatigue ❑ Blurred vision ❑ Social isolation ❑ Nausea/vomiting ❑ Muscle cramps
17. **Reduction contraindicated:** ❑ YES ❑ NO (***If Yes, check for MD note in chart to support risk vs. benefit***) (**Check boxes)**
    ❑ Resident is on optimal dose and is clinically stable ❑ Lower dose causes acute psychotic behavior
    ❑ Lower dose causes resident danger to self and/or others
    ❑ Any GDR would impair function or cause psychiatric instability
    ❑ Other: ____
18. **Psychotherapeutic meds reviewed with Resident/family/legal & consent signed, or documented** ❑ YES ❑ NO
19. **During past 90-days resident's behavior(s)/mood/insomnia has:** ❑Improved ❑Stabilized ❑ Declined ❑ No change
20. **Resident goals and preferences:** ____

    ____

21. **Efficacy of meds reviewed:** ❑ PHQ-9 ❑ BIMS ❑ Global Deterioration Scale ❑ Depression scale ❑ Pain scale ❑ Target Behavior Monitoring ❑ Target Mood Monitoring ❑ Sleep Monitoring ❑ Other_________

Care plan reviewed and revised for medication interventions, goals and monitoring: ❑ Yes ❑ No

Comments: ____

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IDT Signatures:____

____

Name: ____ MR#_____________ Room#__________

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