DD-417-1(8-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY

Division of Developmental Disability

Behavior Modifying Medication Review

To be completed by staff for every medication review. Submit this form to PRC with (1) data form, (2) five-year medication history and (3) behavior treatment plan.

INDIVIDUAL'S NAME (Last, First, M.I.)	ASSISTS NO.	BIRTHDATE	AGE	WEIGHT	HEIGHT

RESIDENCE	DAY PROGRAM	PRIMARY CARE PHYSICIAN

ALL CURRENT MEDICATION

Medication	Dosage	Prescription Date

TO BE COMPLETED BY PSYCHIATRIST/PHYSICIAN

DIAGNOSIS PER CONSENT FORM DSM

TREATMENT PLAN

Medication Prescribed	Dosage	Prescription Date

REASON FOR MEDICATION CHANGE (Attach signed consent)

BEHAVIOR(S) EXPECTED TO BE AFFECTED

CRITERIA FOR MEDICATION REDUCTION

LABORATORY TESTS

RECOMMENDATION FOR BEHAVIOR MANAGEMNET

REVIEWING PSYCHIATRISTS/PHYSICIAN'S SIGNATURE	PRINT REVIEWING PSYCHIATRIST/PHYSICIAN'S NAME	DATE

PERSONS IN ATTENDANCE AT MEDICATION REVIEW

NAME	TITLE	NAME	TITLE
NAME	TITLE	NAME	TITLE
NAME	TITLE	NAME	TITLE

CONSENT FORM(S) DATE	DISCUSS OR AIM DATE (Test for TD)	IPP APPROVAL DATE

FORM COMPLETED BY	DATE