

# Guthrie Mainstream Services

## Behavior Modifying Medication Review

(Complety filled out at every medication review.)

*****SECTION BELOW TO BE COMPLETED BY PROVIDER*****										
INDIVIDUAL'S NAME (Last, First, M.I.)				ASSISTS NO.			BIRTHDATE		DAY PROGRAM	
Current Medication		Dosage			Prescribing Physician			Prescription Date		
Target Behavior(s)	Home Month:	Home Month:	Home Month:	DTA Month:	DTA Month:	DTA Month:				
							Were there any changes in the individuals environment? Yes / No			
							Have there been any observed side effects? Yes / No			
PERSONS IN ATTENDANCE AT MEDICATION REVIEW										
NAME		TITLE			NAME			TITLE		
FORM COMPLETED BY (SIGNATURE)							DATE			
*****SECTION BELOW TO BE COMPLETED BY PSYCHIATRIST*****										
Were medication changes made at this appointment? (circle one) No/Yes If yes, fill out information below.										
Medication Prescribed		Dosage			Reason for medication			Expected affected behavior		
CRITERIA FOR MEDICATION REDUCTION										
LABORATORY TESTS										
RECOMMENDATION FOR BEHAVIOR MANAGEMENT										
REVIEWING PSYCHIATRISTS/PHYSICIAN'S SIGNATURE				PRINT REVIEWING PSYCHIATRIST/PHYSICIAN'S NAME				DATE		
<p>***Changes in Treatment Plan*** (The legal responsible party must be notified of all medication changes. If new medication dose exceeds previously established maximim dosage, a new consent form indicating the new maximum dosage must be obtained. If new medication or increases of doses are prescribed, the Program Review Committee must be notified. All behavior modifying medications must be prescribed in accordance with Article IX.)</p>										