PSYCHIATRIC EVALUATION/PSYCHOTROPIC MEDICATION REVIEW

Date: Doctor: Last Exam Date:

Participant's Name: DOB:

Allergies:

Current Medications, DX's and Diet:

Interdisciplinary Team Review Of Progress And Recommendations

Psychotropic Medication Reduction Plan

See Outcome Report and Documentation

Physician's Plan: _____

_____

_____

_____

_____

Next Appointment Interval:_____

_____
Date

_____
Physician Signature

BEHAVIOR REPORT AND IDT RECOMMENDATIONS

Participant: _____ Visit Date: _____

OBSERVED BEHAVIORS

MOOD

- ☐ Positive, good mood
- ☐ Overactive, "hyper"
- ☐ Isolating Self
- ☐ Breaking Eyeglasses
- ☐ Self Injurious Behavior
- ☐ Pouting
- ☐ Weeping
- ☐ Negative Though Themes
- ☐ Scratching Self
- ☐ Breaking Hearing Aid
- ☐ Biting Self
- ☐ Very Irritable
- ☐ Stays Angry
- ☐ Anxiety
- ☐ Loudness
- ☐ Head Banging

INTERACTIONS WITH PEERS, STAFF

- ☐ Easily Redirected
- ☐ Name Calling
- ☐ Argumentativeness
- ☐ Throwing Things
- ☐ Biting Others
- ☐ Spitting
- ☐ Kicking
- ☐ Refusing Hygiene
- ☐ Resisting Redirection
- ☐ Cursing
- ☐ Threats To Others
- ☐ Bossing
- ☐ Hitting Staff
- ☐ Willful Urination
- ☐ Hair Pulling
- ☐ Malicious Teasing
- ☐ Inappropriate Gestures
- ☐ Refusing Medications
- ☐ Elopement
- ☐ Hitting Peers
- ☐ Lying
- ☐ Refusing To Move
- ☐ Stealing
- ☐ Other

UNUSUAL THOUGHT PROCESSES

- ☐ Perseveration
- ☐ Repeating Phrases
- ☐ Forgetfulness
- ☐ Hallucinations
- ☐ Mental Absences
- ☐ Getting Lost
- ☐ Paranoid Thoughts
- ☐ Difficulty Finding Words
- ☐ Delusions

Description of changes since last visit: ☐ None Significant

What you would like to see happen in this visit? ☐ No Changes

Comments:

Signed:_____ Date: _____

Revised 7/15/2021