MEDICATION MANAGEMENT WORKSHEET

CLIENT'S NAME & CID # ________________________________

Pertinent Vitals/Labs _____ Pulse ______ BP ______ Temp ______ Weight ________________ Fasting Plasma Glucose ______________ Fasting Lipid Profile

Current Medications –Center Prescribed	#	# Refills

Other Prescribed & Over-the Counter Meds - Outside Center

Side Effects/Compliance	√
Medication Compliant	
Dry Mouth	
Muscle Cramps	
Dizziness	
Constipation	
Problems Urinating	
Sexual Dysfunction	
Blurred Vision	
Headaches	
Nausea/Problems/Vomiting/Diarrhea	
Abnormal Involuntary Movements	
Other	

Mental Status		
AFFECT/MOOD	□ anxious/worked □ flat □ depressed □ mood swings □ composed	□ hostile □ euphoric □ labile □ suspicious
SLEEP	□ insomnia □ hypersomnia □ nightmares	□ short intervals □ early awakening □ appropriate
APPETITE	□ increased □ decreased □ anorexia	□ bulimia □ weight changes □ appropriate
ORIENTATION	□ to person only □ disoriented	□ confused □ to all spheres
SUICIDAL IDEAS/ PLANS	□ ideas (document on CSN) □ plans (document on CSN) □ means (document on CSN)	□ history of attempts □ history in family □ denies
HOMICIDAL IDEAS/ PLANS	□ ideas (document on CSN) □ plans (document on CSN) □ means (document on CSN)	□ history of attempts □ history in family □ denies
HALLUCINATIONS	□ auditory □ visual □ multiple (identify all) □ olfactory □ tactile	□ command (list in space) □ denies
DELUSIONS	□ persecution □ grandeur □ reference	□ influence □ somatic □ denies
ALCOHOL/OTHER DRUG USE/ABUSE (if positive for use, identify frequency code)	□ by history only – none current □ signs/symptoms present but denies □ cocaine □ alcohol □ marijuana □ sedatives □ other (list) □ denies	1 occasional 2 2-3 x week 3 4-6 x week 4 daily 5 experiencing blackouts passing out
PATIENT EDUCATION TOPICS COVERED	□ names of medicine □ reasons for medicines □ how to take medicines □ reducing side effects	□ signs and symptoms medication toxicity □ dyskinesia monitoring and TD education

COMMENTS: Services since last contact: □ PMA □ Nursing Service □ IMA □ Crisis Intervention □ Other (Specify) ______________________

(Include effectiveness of medication, interventions, client's response to interventions, client's progress towards goals, plan for next session, justification of continued need for services, client and family feedback).

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Staff Signature and Title **Date** **Direct Service Ticket #**

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Physician's Signature (If Required) **Date**

PRINT ON BLUE PAPER ONLY