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 #**

_____ _____

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

PRINT ON BLUE PAPER ONLY