

BALANCING TEST – PROGRAM PORTION

(required for psychotropics)

INDIVIDUAL: _____

PHYSICIAN: _____

DATE OF REVIEW: _____

FORMAL BEHAVIOR PROGRAM? [] YES [] NO If yes, please attach.

Diagnosis for which medication is prescribed: _____

Description of harmful behaviors: _____

Current medications for behavior

Dosage

Time

A.M.

P.M.

Last Visit: _____. (briefly describe behavioral trends since last visit. Increase? Decrease? Maintenance?) Include frequency data if applicable. Attach graphs or summary of behavioral incidents. _____

Side effects of medications observed? Briefly describe; _____

Environmental or other factors believed to impact behavioral data; (staff changes, illness, etc); _____

Questions for physician; _____

Signature of staff completing this form: _____

BALANCING TEST – PHYSICIAN PORTION

Current diagnosis / recommendations: _____

Potential side effects of medication (s): _____

New / Modified Physicians Orders

Medications	Dosage	Time	A.M.	P.M.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Return visit date: _____

I have reviewed the information presented by program staff and have determined that the harmful effects of the behavior clearly outweigh the potentially harmful side effects of the medication.

(Physicians signature)

(Date)