

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Monitoring of Side Effects Scale (MOSES)

INSTRUCTIONS: See other side. **Bold items below are usually observable.** Regular print items are usually client verbalization, staff input, or chart review.

SCORING: See other side for details.

0 = None 2 = Mild 4 = Severe
1 = Minimal 3 = Moderate NA = Not Assessable

NAME	ID OR UNIT
EXAMINER'S SIGNATURE	DATE
EXAMINER'S NAME AND TITLE	
EXAMINATION TYPE: CHECK ONE	
<input type="checkbox"/> Admission <input type="checkbox"/> Drug initiation <input type="checkbox"/> Baseline <input type="checkbox"/> Six-month <input type="checkbox"/> Other:	

<p>Ears/Eyes/Head 0 1 2 3 4 NA</p> <p>01. Blink Rate: Decreased <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>02. Eyes: Rapid Vert/ Horz <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>03. Eyes: Rolled Up <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>04. Face: No Expression/Masked .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>05. Tics/Grimace..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>06. blurred/double vision .. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>07. ear ringing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>08. headache <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Mouth 0 1 2 3 4 NA</p> <p>09. Drooling/pooling..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>10. Dry Mouth <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>11. Gum Growth..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>12. Mouth/Tongue Movement <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>13. Speech: Slurred/ Difficult/Slow..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Nose/Throat/Chest 0 1 2 3 4 NA</p> <p>14. Breast: Discharge.... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Breast: Swelling.... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Labored Breathing... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>17. Nasal Congestion/ Running Nose <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>18. Sore Throat/ Redness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>19. Swallowing: Difficulty..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Gastrointestinal 0 1 2 3 4 NA</p> <p>20. abdominal pain <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>21. appetite: decreased... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>22. appetite: increased... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>23. constipation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>24. diarrhea <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>25. flatulence <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>26. nausea/Vomiting <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>27. taste abnormality: metallic, etc. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>28. thirst: increased <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>29. weight: decreased <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>30. weight: increased..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>Musculoskeletal/Neurological 0 1 2 3 4 NA</p> <p>31. Arm swing: Decreased..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>32. Contortions/ Neck – Back Arching <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>33. Gait: Imbalance/ Unsteady <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>34. Gait: Shuffling..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>35. Limb jerking/ writhing..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>36. Movement: Slowed/ Lack of..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>37. Pill Rolling..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>38. Restlessness/ Pacing/Can't sit still.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>39. Rigidity/complaints of muscle pain or aches.. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>40. Tremor/Shakiness.... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>41. complaints of jitteriness / jumpiness/ nervousness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>42. fainting/dizziness/ Upon Standing <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>43. seizures: increased <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>44. tingling/numbness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>45. weakness/fatigue <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>Skin 0 1 2 3 4 NA</p> <p>46. Acne..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>47. Bruising: Easy/ Pronounced..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>48. Color: Blue/ Coldness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>49. Color: Flushing/ Warm To Touch..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>50. Color: Pale/Pallor.... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>51. Color: Red/Sunburn/ Photosensitivity <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>52. Color: Yellow..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>53. Dry/Itchy <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>54. Edema..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>55. Hair: Abnormal Growth..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>56. Hair Loss..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>57. Rash/Hives <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>58. Sweating: Decreased..... <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>59. Sweating: Increased <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>60. chills <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	<p>While many of the items in the following two areas are often difficult to determine, please be aware they may occur depending on the specific drug profile. Be certain to inquire about these items from the client if he or she is verbal or from the staff or chart if the client is nonverbal.</p> <p>If seen or reported: check the box next to the item and assign a score next to the item.</p> <p>Urinary/Genital</p> <p>61. <input type="checkbox"/> menstruation: absent / irregular _____</p> <p>62. <input type="checkbox"/> sexual: activity decreased _____</p> <p>63. <input type="checkbox"/> sexual: activity increased _____</p> <p>64. <input type="checkbox"/> sexual: continual erection _____</p> <p>65. <input type="checkbox"/> sexual: erection inability _____</p> <p>66. <input type="checkbox"/> sexual: orgasm difficult _____</p> <p>67. <input type="checkbox"/> urinary retention _____</p> <p>68. <input type="checkbox"/> urination: decreased _____</p> <p>69. <input type="checkbox"/> urination: difficult/painful _____</p> <p>70. <input type="checkbox"/> urination: incontinence / nocturnal enuresis _____</p> <p>71. <input type="checkbox"/> urination: increased _____</p> <p>Psychological 0 1 2 3 4 NA</p> <p>72. Agitation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>73. Confusion <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>74. Crying / feelings of sadness <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>75. Drowsiness/Lethargy/ Sedation <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>76. Irritability <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>77. Withdrawn <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> <p>78. <input type="checkbox"/> attention/concentration difficulty _____</p> <p>79. <input type="checkbox"/> morning "hangover" _____</p> <p>80. <input type="checkbox"/> nightmares /vivid dreams _____</p> <p>81. <input type="checkbox"/> perceptual: hallucinations / delusions _____</p> <p>82. <input type="checkbox"/> sleep: excessive _____</p> <p>83. <input type="checkbox"/> sleep: insomnia _____</p>
OTHER (USE OTHER SIDE IF NEEDED)		MEASURES (MAY USE MOST RECENT MONTHLY CHECK)
		BLOOD PRESSURE PULSE
		TEMPERATURE WEIGHT

Current psychoactive drug regimen. Also list other relevant drugs such as those prescribed to treat side effects. It is not necessary to list the entire drug regimen.

DRUG	MG/DAY	DRUG	MG/DAY

EXAMINER COMMENTS (CROSS – REFERENCE CHART LOCATION IF MORE SPACE IS NEEDED):

PRESCRIBER REVIEW CONCLUSION (CHECK ONE OR MORE)

- | | |
|--|--|
| <input type="checkbox"/> No action necessary | <input type="checkbox"/> Drug discontinuation |
| <input type="checkbox"/> Contra-indicated medication | <input type="checkbox"/> Drug hold |
| <input type="checkbox"/> Dose reduction | <input type="checkbox"/> Lab or other tests/data |
| <input type="checkbox"/> Drug change | <input type="checkbox"/> Other (specify below) |

COMMENTS (CROSS – REFERENCE CHART LOCATION IF MORE SPACE IS NEEDED):

PRESCRIBER'S SIGNATURE

DATE

INSTRUCTIONS:

1. Explain the purpose of the examination. Observe and examine the client for five - 15 minutes in a quiet area.
2. Perform procedures to ascertain items. For example, flex arm for rigidity, open mouth to check throat and saliva, observe arm swing while walking, etc. If the client is verbal, inquire as to problems. For example, for blurred vision ask, "Are you able to see and read all right?" If not, "Describe this to me." Ask at least one open-ended question such as, "Have you noticed any problems?" Talk to staff and review available data for items unable to be observed during the examination such as eating or sleeping, especially for non-verbal individuals.
3. If a sign or symptom is present, it is scored. This does not mean the clinical manifestation (CM) is a side effect. If a reason for the CM exists, explain in Examiner Comments (or cross-reference prior explanation). For example, severe tremor is scored, but is part of Parkinson's disease.
4. If you are not the prescriber, provide the assessment to the prescriber for review and signature. If an issue of concern is present, immediately contact the prescriber and document.
5. The prescriber reviews the assessment, determines any further action, and signs form.
6. File in client chart according to facility procedure. Review at next scheduled team meeting and document status.

SCORING:

- 0 = NOT PRESENT:** Not observed or, if seen, within the range of normal.
- 1 = MINIMAL:** Difficult to detect or easy to detect but occurs only once or twice in a short non-intense manner ("a little bit"). Questionable if the item is in the upper range of normal. The client does not notice or comment on the item
- 2 = MILD:** Infrequent and easy to detect ("sometimes") or an annoyance to the client. While the item does not hinder the client's normal pretreatment functioning level and does not produce extreme discomfort, the item may progress to future severity or problems if ignored.
- 3 = MODERATE:** Frequent and easy to detect ("a lot") or producing some degree of impairment to functioning. Although not hazardous to health, the item is uncomfortable or embarrassing to the client.
- 4 = SEVERE:** Almost continuous, intense, and easy to detect ("all the time") or significant impairment of functioning or incapacitation. The item produces a definite hazard to health or well-being.
- NA = NOT ASSESSED:** An assessment for an item is not able to be made.