

Psychoactive Medication Treatment Plan

PRINT CLIENT NAME	DATE OF BIRTH	DATE
SUPPORTING AGENCY		TELEPHONE NUMBER
Description of behavior(s) for which medication is prescribed and mental health diagnosis, if available:		
MEDICATION(S)	DOSAGE AND FREQUENCY	
Trial period (how long before an effect should be noticed):		
Behavioral criteria to evaluate effectiveness of medication (what changes in behavior, mood, thought or functioning should be expected):		
Potential interactions with other drugs/food:		
PRESCRIBING PROFESSIONAL		TELEPHONE NUMBER
RETURN FOR MEDICATION MONITORING <input type="checkbox"/> 1 month <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> Other:		PRINT NAME OF PERSON COMPLETING FORM

Information on medication: Attach information sheet(s) that describe the medication, dosage ranges, possible side effects and potential adverse drug interactions.

Questions regarding the use of this medication should be addressed to the prescribing professional listed below.

NAME		TELEPHONE NUMBER
Information reviewed with the client/legal representative on:	PRINT NAME OF PERSON COMPLETING FORM	
TO BE COMPLETED BY CLIENT/LEGAL REPRESENTATIVE		
I have received information on this medication, the reasons for its use, and I have had the opportunity to get my questions about it answered.		
SIGNATURE OF CLIENT		DATE
SIGNATURE OF CLIENT'S LEGAL REPRESENTATIVE		DATE