Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Psychoactive Medication Treatment Plan

PRINT CLIENT NAME	DATE OF BIRTH	DATE
SUPPORTING AGENCY		TELEPHONE NUMBER (AND AREA CODE)

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 (AND AREA CODE)
RETURN FOR MEDICATION MONITORING ☐ 1 month ☐ 3 months ☐ 6 months ☐ 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 (AND AREA CODE)
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