"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

MEDICATION MONITORING CHECKLIST

Prescribing Physician _____ Assigned Therapist _____ Review Date _____

Client Name _____ MH # _____ Intake Date _____

REVIEW CHECK LIST (If NO is checked, was there documentation in the chart? Explain or discuss on back of the form.)

N/A	YES	NO	
			INFORMATION ON ALLERGY LABEL (FRONT COVER OF CHART) IS ACCURATE
❍	❍	❍	Does the information on the allergy label correspond with allergy information on PIN and/or assessment?
			NO MEDICATIONS ARE CURRENTLY PRESCRIBED
❍	❍	❍	Does the reviewer agree with the appropriateness of the decision based on the documented clinical evidence?
			MEDICATIONS ARE CURRENTLY PRESCRIBED
❍	❍	❍	1. Are the appropriate medication consent forms completed and signed within the past year?
❍	❍	❍	2. Are the appropriate medications prescribed for the diagnosed condition or clinical situation?
❍	❍	❍	3. Are the medications prescribed at doses consistent with the San Mateo County Medication Guidelines and at effective dose ranges?
❍	❍	❍	4. If multiple medications are used for the same symptoms, are the reasons documented?
❍	❍	❍	5. Was the duration of medication use appropriate before making any clinical adjustments?
❍	❍	❍	6. Is there documented evidence of the evaluation for the presence or absence of adverse reactions or side-effects and are such reactions documented?
❍	❍	❍	7. Is there documented evidence of assessment of drug interactions?
❍	❍	❍	8. If there are or were adverse reactions, is there evidence of clinical response to the reactions such as a change in medications or the addition of a medication to treat side-effects?
❍	❍	❍	9. Is there documented evidence that the clinician evaluated client compliance to the treatment regimen?
❍	❍	❍	10. Is there documented evidence that the clinician has evaluated the response to treatment and indicated the estimated degree of improvement?
❍	❍	❍	11. If there was a limited response to the medication, was the dose adjusted or the medication changed appropriately?
❍	❍	❍	12. If the client has been on the same medication(s) for any length of time, is there evidence that the clinician has assessed the continued appropriateness of the medications(s) or made dose adjustments?
			LABORATORY WORK
❍	❍	❍	1. Was the initial lab work obtained and documented before or at the time of starting medications?
❍	❍	❍	2. If the medication(s) used requires ongoing lab work, has that lab work been obtained in the proper time frame and documented?
			PHYSICAL EXAMINATIONS
❍	❍	❍	1. Is there documented evidence of a current AIMS test and total score, when indicated?
❍	❍	❍	2. Was an initial physical examination performed or reports about a recent examination noted in the chart?
❍	❍	❍	3. Have efforts been made to obtain appropriate health care as needed?

RECOMMENDATIONS

_____

_____

_____

_____

Reviewing Clinician _____

Physician signature, if not reviewer _____

PRESCRIBING PHYSICIAN/ASSIGNED THERAPIST RESPONSE TO RECOMMENDATIONS

_____

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_____

Accepted by Reviewing Clinician (date &initials) _____

Referred to Medical Director (date) _____