Tennessee Department of Children's Services

Psychotropic Medication Evaluation

Note: Complete this form at <u>every</u> medication evaluation appointment. Healthcare Providers may prefer to provide their own documentation regarding information contained in this form.
If new psychotropic medication is prescribed an Informed Consent must be signed and forwarded to the DCS Health unit.

Appointment date _____ TFACTS person ID# _____

Child's name _____ DOB _____

Home County _____ FSW name _____

Provider name _____ Phone # _____

Clinic name _____

Address

DSM-V Diagnosis _____

Symptoms _____

Other Treatments _____

Current and discontinued medications (name, dose, frequency, route, and # of refills)

#1 # of Refills
☐ Increase ☐ Decrease ☐ Discontinued ☐ No change ☐ New

2 # of Refills
☐ Increase ☐ Decrease ☐ Discontinued ☐ No change ☐ New

3 # of Refills
☐ Increase ☐ Decrease ☐ Discontinued ☐ No change ☐ New

4 # of Refills
☐ Increase ☐ Decrease ☐ Discontinued ☐ No change ☐ New

5 # of Refills
☐ Increase ☐ Decrease ☐ Discontinued ☐ No change ☐ New

Reason medication stopped? _____
Reason for changes? _____
Recent Height: _____ Recent Weight: _____ Pulse: _____ BP: _____
Laboratory tests? ☐ No ☐ Yes *(specify)* _____
Other diagnostic tests? ☐ No ☐ Yes *(specify)* _____
Next appointment

Provider signature _____ Date _____

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.
Distribution: SAT Coordinator, Child/Youth's Case File, Health Record