**RESIDENT NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **ROOM:** \_\_\_\_\_\_ **PHYSICIAN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSESSMENT DATE:** \_\_\_\_\_\_\_\_\_ □ Initial assessment □ Continuation assessment  
 PHQ-9 Score/date: \_\_\_\_\_\_\_\_\_\_\_\_ BIMS/CPS Score/date: \_\_\_\_\_\_\_\_\_\_

1. **ANTIPSYCHOTIC** (name/dosage/directions): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Start Date: \_\_\_\_\_\_\_\_\_\_ Last Dosage Change: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Decrease/Increase)

1. **OTHER CONCURRENT CLINICAL CONCERNS:**

|  |  |  |  |
| --- | --- | --- | --- |
| * *Pain* | * *Infection* | * *Constipation* | * *Weight loss* |
| * *Falls* | * *Parkinson’s* | * *Depression* | * *Insomnia* |
| * *Other:* |  |  |  |

1. **REASON FOR ANTIPSYCHOTIC INITIATION:**

* *Dementing Illness with associated behavioral symptoms*
* *Dementia alone*
* *Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*
* *No Indication Identified*

1. **TARGETED SYMPTOMS OR BEHAVIORS (why was it started):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **NONPHARMACOLOGICAL INTERVENTIONS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **BEHAVIORAL TRENDS SINCE LAST ASSESSMENT** (In Documentation**):**

|  |  |
| --- | --- |
| * Behavioral symptoms Decreased | * Behavioral symptoms Increased |
| * No Change in Behavioral symptoms |  |

***SUMMARY*:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **ADVERSE EFFECT MONITORING** (changes from baseline functioning)[**AIMS=** \_\_\_\_date\_\_\_\_\_\_ ]

|  |  |  |  |
| --- | --- | --- | --- |
| * *Drowsiness, sedation or confusion* | * *Dizziness or loss of balance* | * *Falls* | * *Constipation* |
| * *Muscle spasm, tremor, shaking* | * *Uncontrolled movements* | * *Tardive dyskinesia* | * *Vision changes* |
| * *Swallowing difficulty* | * *Speech difficulty* | * *Headache* | * *Weight gain* |
| * *Dry mouth* | * *Drooling* | * *Increased skin sensitivity* | * *Restlessness or anxiety* |
| *Other:* | *Other:* | * *NO Apparent ADR’s reported* |  |

***M3 COMMITTEE SUMMARY OF BEHAVIORAL TRENDS & ANTIPSYCHOTIC USAGE:***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **M3 COMMITTEE RECOMMENDATION** (Date:)**:**

[*Always consider a dose reduction even if it may have failed in the past*]

* + ***Gradual Dosage Reduction at this Time:***
* Recommended dose reduction (write new orders): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  + ***Gradual Dosage Reduction NOT indicated due to (BOTH requirements must be met):***
* Previous attempt at GDR resulted in reoccurrence of behavioral symptoms (documented date: \_\_\_\_\_\_\_\_\_) ; **AND**
* Clinical rationale why an attempt at GDR would likely impair this resident’s function or increase their distressed behavior: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  + ***Recent Dosage Change*** *(<60 days)****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***
  + ***Will Consider GDR when Resident is Clinically Stable:***
* Clinical Rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* ***Recommend Additional Clinician Assessment of Behavioral Symptoms with Follow-up Report at Next Scheduled Meeting***

***M3 Committee Members:***

Medical Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Executive Director: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.N.: \_\_\_\_\_\_\_\_\_\_\_\_\_

Consultant Pharmacist: \_\_\_\_\_\_\_\_\_\_\_\_ Social Services: \_\_\_\_\_\_\_\_\_\_\_\_ Nurse Manager: \_\_\_\_\_\_\_\_\_\_\_

1. **ATTENDING PHYSICIAN ASSESSMENT** (Date: \_\_\_ ):
   * ***I Agree with M3 Committee’s recommendation (follow recommendation above)***
   * ***I Agree with M3 Committee’s recommendations*, but with these orders:**
     + ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***
   * ***I Disagree with M3 Committee’s recommendations because (specific clinical rationale for this resident required):***
     + \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PHYSICIAN SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**ORDERS CONFIRMED BY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_