

# Monthly PRN Psychotropic Medication Review



RESIDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

FACILITY: \_\_\_\_\_ ROOM #: \_\_\_\_\_

REVIEW FOR YEAR \_\_\_\_\_ Month (circle): 1 2 3 4 5 6 7 8 9 10 11 12

**Community-Based Residential Facilities Regulation DHS 83.37(1)(i)2. As needed (PRN) psychotropic medication.**

*The administrator or qualified designee shall monitor at least monthly for inappropriate use of PRN psychotropic medication, including but not limited to, use contrary to the individual service plan, presence of significant adverse side effects, use for discipline or staff convenience, or contrary to the intended use.*

Medication Reviewed: \_\_\_\_\_ Strength: \_\_\_\_\_

Directions: \_\_\_\_\_

Identified Behavior: \_\_\_\_\_

1. Is the above medication used in accordance with the Individual Service Plan (ISP)?  No  Yes

If no, explain: \_\_\_\_\_  
\_\_\_\_\_

2. Is there a presence of significant adverse side effects?  No  Yes

If yes, list specific side effects observed: \_\_\_\_\_  
\_\_\_\_\_

3. Is the above medication being used for discipline, staff convenience, or contrary to the intended use?

No  Yes

If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

4. Is prescriber follow up necessary?  No  Yes

**Follow Up / Actions necessary:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Review performed by: \_\_\_\_\_ Date: \_\_\_\_\_