

PSYCKES Clinical Note

Client Name:	Date:
Psychotropic (or clinic) prescriber:	Medicaid ID:
Other prescriber:	

- **CM Risk**
 - Metabolic Condition Diabetes Hyperlipidemia Hypertension Obesity
 - CVD High Risk Antipsychotic(s) _____
- **Polypharmacy**
 - 2AP 3AP 2AD 3AD 4PP (adults) 3PP (youth)
- **High Dose**
 - **Adults:** AP AD MS ADHD ANX
 - **Youth:** AP AD MS ADHD ANX
- **Youth (0-18)**
 - ≥3PP High Dose Psychotropics under 6 y/o

Current Medications:

Medication Plan

Change	No Change
Plan <input type="checkbox"/> Discontinue _____ <input type="checkbox"/> Begin taper of _____	Rationale <input type="checkbox"/> Client released from hospital in past 3 months <input type="checkbox"/> Client prefers to stay on current regimen <input type="checkbox"/> AOT order specifies current regimen <input type="checkbox"/> Antipsychotic polypharmacy used for clozapine augmentation <input type="checkbox"/> Medication prescribed by outside provider <input type="checkbox"/> Unsuccessful attempt to reduce medications in the past 3 months <input type="checkbox"/> 3 previous trials of monotherapy at adequate dose for adequate time <input type="checkbox"/> Client has history of serious violence to self or others <input type="checkbox"/> Other: _____
Plan Supports <input type="checkbox"/> Define/discuss early warning signs of relapse <input type="checkbox"/> Use rating scale _____ <input type="checkbox"/> Call to check in on client <input type="checkbox"/> Increase therapist/RN involvement <ul style="list-style-type: none"> <input type="checkbox"/> Telephone check in <input type="checkbox"/> Discuss med concerns/adherence at next appointment <input type="checkbox"/> Meet with client/family/social supports <input type="checkbox"/> Increase frequency of visits <input type="checkbox"/> Offer medication education groups <input type="checkbox"/> Other: _____	
Notes:	Plan to Address Barriers to Change <input type="checkbox"/> Reassess in ___ months <input type="checkbox"/> Therapist to engage client around concerns <input type="checkbox"/> Provide medication education materials <input type="checkbox"/> Contact other prescribers of medication <ul style="list-style-type: none"> <input type="checkbox"/> Contact info in chart <input type="checkbox"/> Consent done <input type="checkbox"/> Offer medication group/peer support <input type="checkbox"/> Other: _____
Signature: _____	