

**GNYHA PSYCKES QUALITY COLLABORATIVE
ANTIPSYCHOTIC MEDICATIONS POSING A RISK OF CARDIOMETABOLIC SIDE EFFECTS**

NEW STARTS CHECKLIST

To be completed before initiation of any antipsychotic medication posing a moderate or high risk of cardiometabolic side effects.

For adults: olanzapine, quetiapine, chlorpromazine, thioridazine.

For children/adolescents: ALL antipsychotics EXCEPT aripiprazole and ziprasidone.

- | | Col A | Col B | |
|---|---|------------------------------|---|
| 1 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Does the client report a diagnosis of any cardiometabolic condition (including diabetes, pre-diabetes, high triglycerides, low HDL, hypertension, obesity and/or cardiovascular disease)? |
| 2 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Is the client taking any medication used to treat the above conditions? |
| 3 | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Is there documentation indicating that the client has any of the above conditions, in the medical record (and/or in PSYCKES, if applicable)? |
| 4 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you obtained a family history of cardiometabolic conditions and ischemic vascular disease, including age at onset? |
| 5 | Do you have the results of the following diagnostic tests for the client, dated within the past 6 months (or as clinically appropriate)? | | |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fasting glucose level |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fasting triglyceride levels / fasting HDL cholesterol level |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Waist circumference / BMI |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Blood pressure |
| | <input type="checkbox"/> Yes | <input type="checkbox"/> No | ECG (if indicated) |
| 6 | Based on all of the above data sources, is the client diagnosed with / being treated for / exhibiting signs and symptoms of any of the following? | | |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Diabetes? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Pre-diabetes? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hypertriglyceridemia? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Obesity? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Hypertension? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Ischemic Vascular Disease (cardiovascular/ cerebrovascular/ peripheral vascular)? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Metabolic syndrome? |
| | <input type="checkbox"/> No | <input type="checkbox"/> Yes | Strong family history of diabetes and/or ischemic vascular disease with early onset? |

If you answered "No" to all items in question #6, then STOP, you have completed this form.

If you have answered "Yes" to any items in question #6, please continue with this form.

- 7 Yes No Does the client have a psychotic disorder?
If yes, skip to # 9
- 8 Yes No (If no psychotic disorder) Has the client had adequate trials of: (1) a medication other than an antipsychotic, (2) an evidence-based psychosocial treatment *AND* (3) an antipsychotic that is in the low risk category for metabolic side effects? If yes, please specify:
(Check No if unknown)
If yes, specify → _____
- 9 Yes No (If the client has a psychotic disorder) Has the client had a trial of at least ONE medication (for children: one non-antipsychotic medication) that is in the low risk category for cardiometabolic side effects at an adequate dose for an adequate period of time? If yes, please specify: _____
(Check No if unknown)
If yes, specify → _____
- 10 No Yes Are there safer medications that may be effective?

If any boxes in Column B above are checked, please consult with the Program Director/ Medical Director before recommending a course of a moderate- or high-risk antipsychotic medication. In addition, before initiating the medication regimen, please complete the following steps:

- 11 Yes No Have the benefits and risks of the proposed regimen, including cardiometabolic risk, been discussed with the client, family and/or legal guardian, as appropriate?
- 12 Yes No Is the rationale for this medication regimen clearly documented in the chart?
- 13 Yes No (For children only) Is there a plan to provide concurrent psychosocial treatment? Specify provider(s) and frequency: _____
- 14 Yes No Is there a plan to monitor the client regularly for changes in cardiometabolic indicators in accordance with the protocol below? Specify provider(s) and frequency: _____

**American Diabetes Association
Consensus Monitoring Protocol for Individuals on Second Generation Antipsychotics***

	Baseline	4 Weeks	8 Weeks	12 Weeks	Quarterly	Annually	Every 5 Yrs
Personal/family	X					X	
Weight (BMI)	X	X	X	X	X		
Waist circumference	X					X	
Blood pressure	X			X		X	
Fasting plasma	X			X		X	
Fasting lipid profile	X			X			X

*More frequent assessments may be warranted based on clinical status

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