Q.I. Confidential Information

QUALITY IMPROVEMENT – HHSA-MHS ADULT/OLDER ADULT OUTPATIENT MEDICATION MONITORING SCREENING TOOL

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Please complete all boxes on this form with legible writing or type

Program:	**Psychiatrist:**
Client:	**Review Date:**
Case #:	**Reviewer:**

	CRITERIA	COMPLIANCE Yes	No	NA	COMMENTS
1.	**Medication rationale and dosage is consistent with community standards.**	☐	☐	☐	
2.	**a. Were labs indicated?**	☐	☐	☐	
	b. Were lab results obtained?	☐	☐	☐	
	c. Were labs reviewed by Medical Staff?	☐	☐	☐	
	d. Were lab results reviewed with the client?	☐	☐	☐	
	e. Were lab results present in chart?	☐	☐	☐	
	f. If labs indicated change(s) to medication treatment, were such change(s) made?	☐	☐	☐	
3.	**Physical health conditions and treatment considered when prescribing psychiatric medication.**	☐	☐	☐	
4.	**No more than 2 medications of each chemical class concurrently without a clearly documented rationale.**	☐	☐	☐	
5.	**Adverse drug reactions and/or side effects treated and managed effectively.**	☐	☐	☐	
6.	**A signed consent form evidences informed consent.**	☐	☐	☐	
7.	**Documentation is in accordance with prescribed medication.**	☐	☐	☐	
	Documentation includes client's:				
8a.	**Response to medication therapy.**	☐	☐	☐	
8b.	**Presence/absence of side effects.**	☐	☐	☐	
8c.	**Extent of client's adherence with the prescribed medication regime and relevant interventions.**	☐	☐	☐	
8d.	**Client's degree of knowledge regarding management of his/her medication(s).**	☐	☐	☐	
TOTAL (Please total the YES/NO columns) ***Please complete a McFloop form if there are any variances.***					