QUALITY IMPROVEMENT – HHSA- MHS
CHILDREN'S MEDICATION MONITORING SCREENING TOOL

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

Program:	**Review Date:**
Client (first name only):	**Case #:**
Treating Psychiatrist:	
Reviewer:	

PLEASE NOTE: ALL "NO" ANSWERS REQUIRE A MCFLOOP FORM.

	CRITERIA	**COMPLIANCE** Yes	No	NA	**COMMENTS**
1.	**Were medication rationale and dosage consistent with standard of care in Child and Adolescent Psychiatric community?**	☐	☐		
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	**Were physical health conditions and treatment considered when prescribing psychiatric medication?**	☐	☐	☐	
4.	**For each class of meds below please indicate whether there was clearly documented rationale for prescribing <u>more</u> than 1 medication in each category:**				**"No" answer means that the rationale was not clearly documented <u>and</u> client is on more than 1 med. in that class. Put N/A if client doesn't take this medication.**
	a. Stimulants	☐	☐	☐	
	b. Mood Stabilizer	☐	☐	☐	
	c. Antidepressants	☐	☐	☐	
	d. Antipsychotics	☐	☐	☐	
	e. Antiparkinsonian	☐	☐	☐	
5	**Were Adverse Drug Reactions and/or Side Effects treated and managed effectively?**	☐	☐	☐	
6.	**Was informed consent obtained, as evidenced by a signed consent form or ex-parte order?**	☐	☐	☐	

7.	**Was the diagnosis in concordance with prescribed medication?**	☐	☐	☐	
8.	**Did treating M.D. document:**				
	a. client's response to medication therapy?	☐	☐	☐	
	b. the presence/absence of side effects?	☐	☐	☐	
	c. the extent of client's compliance with the prescribed medication regime and relevant interventions?	☐	☐	☐	
	d. measures taken to educate client/parent in regard to medication management?	☐	☐	☐	