Addressograph

Antipsychotic Medication Review

Resident's Name: ____

1. Indication for Review
   a. Newly admitted resident on antipsychotic medication
   b. Newly prescribed antipsychotic medication
   c. Quarterly review

2. Antipsychotic Medications, dosage, frequency and time of administration

Medication	Dosage	Frequency and Time of Administration

3. Indication for use- Indicators per Ministry

Psychosis		Hallucinations / Delusions		Huntington's		Schizophrenia	

Other Appropriate Uses

BPSD		Paranoia / Suspicion		Agitation		Bipolar Disorder	
Neurological conditions		Palliative Care		Other:			

4. Alternatives that have been trialed or considered prior to introduction of antipsychotic medication and in conjunction with antipsychotic medication.

Assessment/Intervention		**Yes/No**
Pain (list pain score and medication)	Pain Score / date:	
Depression (list GDS, CSDD and medication if applicable)	GDS / date:	
	CSDD Score / date:	
Blood work		
Urinalysis		
Review of Toileting Plan		
Montessori Programming		
Music Therapy		
Restorative Care/PT/OT		
Social Work/BSO Involvement		
Review of Current Medications		

Resident Name ___________________________

5. Have there been recent changes to antipsychotic medication (dosing, time of administration increase or decrease in PRN use) in the past quarter? What where the effects noted?

6. Gradual Dose Reduction (GDR) - Has it been attempted in the past quarter? What was the effect? Is GDR appropriate at this time?

7. Has the resident experienced any adverse effects from the antipsychotic medication?

Potential adverse effect	**Yes/No**		**Yes/No**
Arrhythmias (last EKG)		EPS (including rigidity, tremors, changes to gait)	
Change to blood pressure		Sedation	
Increase in confusion		Changes to swallowing abilities	
Increase in falls		Weight changes	
Dizziness		Hyperglycemia/Hypoglycemia	
Insomnia		Other	

8. What was the action taken if adverse effects noted?

9. Has the care plan been updated accordingly with safe guards in place?

Registered Staff completing Review: _______________________________ Date: ______________

Pharmacist Signature(if applicable): _______________________________ Date: ______________

Practitioner Review and Comments: ____

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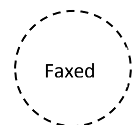
Signature of Practitioner: ______________________________ Date: ______________

Faxed to iPharm ___________



Woodingford Lodge Embedded BSO Team