

CLCM Foster Home Physician's Visit/order Form

DOB: _____ Allergies: _____ Date: _____

Client: _____ Attending Physician: _____

Reason(s) for visit; condition/complaints:

Current Prescribed Medications, Treatments, Procedures, and PRN'S:

Medication/Treatment/Procedure/PRN	Dosage & Frequency	Name of prescribing physician

Summary of Visit:

New Orders & Instructions: (Please note any ending dates for new orders)

I have reviewed the client's current medications and they are correct as shown on this form. Signature constitutes an order for medications prescribed by signing physician.

Physician/Nurse Practitioner Signature

Date

Balancing Test Form

To be used when psychotropic medications are first prescribed and annually thereafter



Client name: _____ Date of birth: _____

Medication name: _____

Prescribed by: _____ Date ordered: _____

Oregon Administrative Rule (411-325-0360, 411-346-0190; 411-360-0140)

- Requirements:** Psychotropic medications and medications for behavior must be:
 - Prescribed by physician or health care provider through a written order; and
 - Monitored by the prescribing physician, ISP team and program for desired responses and adverse consequences.
- Balancing test:** When medication is first prescribed and annually thereafter, the provider must obtain a signed balancing test from prescribing health care provider using the DHS Balancing Test form. Providers must present the physician or health care provider with a full and clear description of the behavior and symptoms to be addressed, as well as any side effects observed.
- Documentation requirements:** The provider must keep signed copies of these forms in the individual's medical records for seven (7) years.

Service provider

Describe the behavior and its potentially harmful effects:

Describe the potential side effects of the medication:

Prescribing physician or health care provider discussion

The provider supporting this individual in their home is required to present me with a full and clear description of the behavior or symptoms of the condition to be treated by the psychotropic medication and information on any observed side effects. If needed, the information requested may include the frequency, intensity and circumstances around the symptoms. **Was this provided?** Yes No

The Federal Centers of Medicare and Medicaid (CMS) expect the judicious use of psychotropic medications to avoid chemical restraints. I have reviewed the information given me and believe the use of this medication is in the best interests of this individual.

Monitoring requirements

Physician or health care provider:

Service provider:

Signature of physician or health care provider

Date