PATIENT AT RISK FORM (PAR) FOR ANTIPSYCHOTIC MEDICATION REDUCTION

Instructions: Please complete this form for residents included in Antipsychotic Reduction

RESIDENT NAME:			**ROOM #**	**DATE:**	
PREVIOUS ORDER:		**DATE:**	**NEW ORDER:**		**DATE:**
DIAGNOSIS FOR ANTIPSYCHOTIC MEDICATION:					
BEHAVIOR(S) THAT TRIGGERED ANTIPSYCHOTIC USE:	☐ Delusions	☐ Pinching	☐ Biting	☐ Spitting	☐ Cursing
DATE OF ONSET:	☐ Resists ADL Care	☐ Paranoia	☐ Screaming	☐ Crying	☐ Hallucinations
	☐ Anxiety	☐ Wandering	☐ Other:		
ANY DOCUMENTED SIDE EFFECTS FROM ANTIPSYCHOTIC USAGE?	☐ None	☐ Sedation	☐ Parkinsonism	☐ New Onset Confusion	☐ Postural/ Orthostatic Hypotension
DATE OF ONSET:	☐ Akathisia	☐ Confusion	☐ Constipation	☐ Tardive Dyskinesia	☐ Other:
SINCE REDUCTION, HAS THE RESIDENT EXPERIENCED ANY INCREASE IN SYMPTOMS OR ANY NEW SYMPTOMS?	☐ Delusions	☐ Pinching	☐ Biting	☐ Spitting	☐ Anxiety
	☐ Kicking	☐ Paranoia	☐ Screaming	☐ Crying	☐ Hallucinations
	☐ Agitation	☐ Wandering	☐ Insomnia	☐ Restlessness	☐ Fidgeting
	☐ Nervousness	☐ Unsociability	☐ Other:		
ANY NEW MEDICAL CONDITIONS SINCE REDUCTION?	☐ Fever	☐ UTI	☐ Cardiac Issues	☐ Vomiting	☐ Edema in Extremities	☐ Respiratory Distress
DATE OF ONSET:	☐ Pain	☐ CHF	☐ Pneumonia	☐ Nausea	☐ Impaired Memory	☐ Other:
FAMILY NOTIFIED OF REDUCTION ON:	**DATE:**		**TIME:**		
NAME OF FAMILY MEMBER NOTIFIED:			FAMILY NOTIFIED OF REDUCTION BY (STAFF NAME):		
NARRATIVE:					

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