MULTIDISCIPLINARY MEDICATION MANAGEMENT COMMITTEE

ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

RESIDENT NAME: _____________________ ROOM: ________ PHYSICIAN: ___________________

ASSESSMENT DATE: __________ □ Initial assessment □ Continuation assessment
PHQ-9 Score/date: __________ BIMS/CPS Score/date: __________

A. ANTIPSYCHOTIC (name/dosage/directions): ___________________________________________
   • Start Date: ___________ Last Dosage Change: ___________ (Decrease/Increase)

B. OTHER CONCURRENT CLINICAL CONCERNS:
   - Pain
   - Infection
   - Constipation
   - Weight loss
   - Falls
   - Parkinson’s
   - Depression
   - Insomnia
   - Other:

C. REASON FOR ANTIPSYCHOTIC INITIATION:
   - Dementing Illness with associated behavioral symptoms
   - Dementia alone
   - Other: ________________________________
   - No Indication Identified

D. TARGETED SYMPTOMS OR BEHAVIORS (why was it started):

E. NONPHARMACOLOGICAL INTERVENTIONS:

F. BEHAVIORAL TRENDS SINCE LAST ASSESSMENT (In Documentation):
   - Behavioral symptoms Decreased
   - No Change in Behavioral symptoms
   - Behavioral symptoms Increased

SUMMARY: ________________________________________________________________

G. ADVERSE EFFECT MONITORING (changes from baseline functioning) [AIMS= ________ date ________]

   - Drowsiness, sedation or confusion
   - Dizziness or loss of balance
   - Falls
   - Constipation
   - Muscle spasm, tremor, shaking
   - Uncontrolled movements
   - Tardive dyskinesia
   - Vision changes
   - Swallowing difficulty
   - Speech difficulty
   - Headache
   - Weight gain
   - Dry mouth
   - Drooling
   - Increased skin sensitivity
   - Restlessness or anxiety
   - Other:
   - Other:
   - NO Apparent ADR's reported

M3 COMMITTEE SUMMARY OF BEHAVIORAL TRENDS & ANTIPSYCHOTIC USAGE:

________________________________________________________________________
________________________________________________________________________
H. **M3 COMMITTEE RECOMMENDATION** (Date: ___):

[Always consider a dose reduction even if it may have failed in the past]

☐ **Gradual Dosage Reduction at this Time:**
  - Recommended dose reduction (write new orders):
    -

☐ **Gradual Dosage Reduction NOT indicated due to (BOTH requirements must be met):**
  - Previous attempt at GDR resulted in reoccurrence of behavioral symptoms (documented date: _______); **AND**
  - Clinical rationale why an attempt at GDR would likely impair this resident's function or increase their distressed behavior:
    -

☐ **Recent Dosage Change** (<60 days): __________________________

☐ **Will Consider GDR when Resident is Clinically Stable:**
  - Clinical Rationale: __________________________________________

☐ **Recommend Additional Clinician Assessment of Behavioral Symptoms with Follow-up Report at Next Scheduled Meeting**

**M3 Committee Members:**
Medical Director: ____________ Executive Director: ____________ D.O.N.: ____________
Consultant Pharmacist: ____________ Social Services: ____________ Nurse Manager: ____________

I. **ATTENDING PHYSICIAN ASSESSMENT** (Date: ___):

☐ **I Agree with M3 Committee’s recommendation (follow recommendation above)**

☐ **I Agree with M3 Committee’s recommendations, but with these orders:**
  -

☐ **I Disagree with M3 Committee’s recommendations because (specific clinical rationale for this resident required):**
  -

**PHYSICIAN SIGNATURE:** ________________ Date: ______

ORDERS CONFIRMED BY: ________________ Date: ______