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	❑ Behavioral symptoms Increased
❑ No Change in Behavioral symptoms	

***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:

_____
_____
_____

ANTIPSYCHOTIC USE IN DEMENTIA ASSESSMENT

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: _____