DD-417-1 (8-06)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

BEHAVIOR MODIFYING MEDICATION REVIEW

To be completed by staff for every medication review. Submit this form to PRC with (1) data form, (2) five-year medication history and (3) behavior treatment plan.

INDIVIDUAL'S NAME *(Last, First, M.I.)*	ASSISTS NO.	BIRTHDATE	AGE	HEIGHT	WEIGHT

RESIDENCE	DAY PROGRAM	PRIMARY CARE PHYSICIAN

ALL CURRENT MEDICATION

Medication	Dosage	Prescription Date

TO BE COMPLETED BY PSYCHIATRIST/PHYSICIAN

DIAGNOSIS PER CURRENT DSM

TREATMENT PLAN

Medication Prescribed	Dosage	Prescription Date

REASON FOR MEDICATION CHANGE *(Attach signed consent)*

BEHAVIOR(S) EXPECTED TO BE AFFECTED

CRITERIA FOR MEDICATION REDUCTION

LABORATORY TESTS

RECOMMENDATION FOR BEHAVIOR MANAGEMENT

Distribution: **Original** – Support Coordinator/Case File; **Yellow** – Residential/Medical File; **Pink** – Day Program File.