**Alameda County Behavioral Health Care Services (ACBHCS)**

**Short-Term Residential Therapeutic Program (STRTP)**

**MEDICATION REVIEW – MEDICATION NOT PRESCRIBED**

**\* Completed a minimum of every 90 days for youth residing in an STRTP who are not prescribed psychotropic medication.**

**Client’s Name: Client’s Pronouns:**

**Case #: STRTP Name:**

**Date of Admission:**

1. **Diagnosis** (Include rule out(s). Include status: improved, well-controlled, resolving or resolved; or inadequately controlled, worsening, or failing to change as expected):
2. **Psychiatric Exam** (Description of speech, thought process, associations, abnormal or psychotic thoughts, judgment and insight, MSE, SI/HI, etc.):
3. **Plan of Care** (Include recommendations for care, psychotherapeutic needs, progress on recovery/resiliency goals etc.):

**The Psychiatrist has reviewed the course of treatment and considered the goals and objectives of the Client Plan**:

**☐ Yes ☐ No** *Psychiatrist must review client plan per STRTP requirements.*

If no, provide an explanation:

**\*Signature/Title/Credential \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_**

**Printed Name/Credential \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff ID#\_\_\_\_**

\*I certify that the service(s) shown on this sheet were provided by me personally and the service(s) were medically necessary.

**Co-Signature/Title/Credential\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_**

**Printed Name/Credential ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Staff ID#\_\_\_\_**