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

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

**MEDICATION REVIEW**

**Client’s Name: Client’s Pronouns:**

**Case #: STRTP Name:**

**Date of Admission:**

**For children and youth prescribed psychotropic medication, a Medication Review shall be completed as often as clinically appropriate, but at least every forty-five (45) days.**

1. Observations of any side effects and review of any side effects reported by the child or noted in the client record:
2. The child’s response to each psychotropic medication currently prescribed and the child’s perspective on the effectiveness of these medications *(include the child’s thoughts/feelings about taking medication)*:
3. The child’s compliance with taking psychotropic medication prescribed:
4. Justification for continuing to prescribe psychotropic medication and/or changing the child’s medication plan:

1. The Prescribing Physician has considered the goals and objectives of the Client Plan and medication prescribed is consistent with this Plan: **☐ Yes ☐ No**

If no, provide an explanation of needed updates to the Client Plan:

**\*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#\_\_\_\_**