

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:**

<input type="checkbox"/> Pain	<input type="checkbox"/> Infection	<input type="checkbox"/> Constipation	<input type="checkbox"/> Weight loss
<input type="checkbox"/> Falls	<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Depression	<input type="checkbox"/> Insomnia
<input type="checkbox"/> 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):**

<input type="checkbox"/> Behavioral symptoms Decreased	<input type="checkbox"/> Behavioral symptoms Increased
<input type="checkbox"/> No Change in Behavioral symptoms	

SUMMARY: _____

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

<input type="checkbox"/> Drowsiness, sedation or confusion	<input type="checkbox"/> Dizziness or loss of balance	<input type="checkbox"/> Falls	<input type="checkbox"/> Constipation
<input type="checkbox"/> Muscle spasm, tremor, shaking	<input type="checkbox"/> Uncontrolled movements	<input type="checkbox"/> Tardive dyskinesia	<input type="checkbox"/> Vision changes
<input type="checkbox"/> Swallowing difficulty	<input type="checkbox"/> Speech difficulty	<input type="checkbox"/> Headache	<input type="checkbox"/> Weight gain
<input type="checkbox"/> Dry mouth	<input type="checkbox"/> Drooling	<input type="checkbox"/> Increased skin sensitivity	<input type="checkbox"/> Restlessness or anxiety
Other: _____	Other: _____	<input type="checkbox"/> 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: _____