PSYCHOTROPIC MEDICATION REVIEW

Name: _____ Date: _____

Physician: _____ Host Home: _____

Medications: (Include name, dosage and diagnosis)

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Abnormal Involuntary Movement Scale

Facial and oral movements

• Muscles of facial expression	1	2	3	4	5
• Lips and peri-oral area	1	2	3	4	5
• Jaws	1	2	3	4	5
• Tongue (Increase in movement in & out)	1	2	3	4	5

Extremity Movements

• Upper Extremities	1	2	3	4	5
• Lower Extremities	1	2	3	4	5

Trunk Movements

• Neck, Shoulders, Hips, Chest	1	2	3	4	5

Global Judgments

- Severity of abnormal movements
  Normal (None) Mild Moderate Severe
- Incapacitation due to abnormal movements
  Normal (None) Mild Moderate Severe
- Patient's awareness of abnormal movements
  Normal (None) Mild Moderate Severe

Dental

- Current problems with teeth and/or dentures YES NO
- Does patient usually wear dentures YES NO

Comments:

Physician's Signature: _____ Date: _____

Next Appointment Date: _____

Rating Key – (1) None (2) Minimal (3) Mild (4) Moderate (5) Severe