



# FUTURES COMMUNITY SUPPORT SERVICES, INC.

## PSYCHIATRIC MEDICATIONS & BEHAVIOR REVIEW REPORT

Name: \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Date: \_\_\_\_\_

Staff: \_\_\_\_\_

Name and Dosage of Current Medications:

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Reason for Psychotropic Medications / Diagnosis:

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Need to continue:                      NO \_\_\_\_\_                      YES \_\_\_\_\_

Please indicate any changes:

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Need for Blood Levels:      NO \_\_\_\_\_                      YES \_\_\_\_\_ \* Meds Needing Levels

Current (Last) Levels:

Medication: \_\_\_\_\_ Level: \_\_\_\_\_      Medication: \_\_\_\_\_ Level: \_\_\_\_\_

\_\_\_\_\_

Follow Up Appointment In: \_\_\_\_\_

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date