"CONFIDENTIAL PATIENT INFORMATION: See California Welfare and Institutions Code Section 5328"

MEDICATION MONITORING CHECKLIST

Treating Physician/NP	
Reviewing Physician/NP	
Client Name & medical record number:	

1. Allergy Information

Yes	No	N/A	
☐	☐	■	Is there allergy information (including NKDA) in Order Connect?
☐	☐	■	Is there any discrepancy between the allergy information in Order Connect and the allergy information in the chart (e.g., PIN and/or progress notes)?

2. Medications prescribed?

Yes	No	N/A	
☐	☐	■	Are medications currently prescribed? • If YES, please SKIP the next question and go to Section 3 • If NO medications prescribed, please answer next question.
☐	☐	■	• If NO medications prescribed, does the reviewer agree with the clinical decision making (e.g., medications not indicated or client declining medication recommendations)? • Please SKIP sections 3, 4 & 5.

3. If medications are currently prescribed:

Yes	No	N/A	
☐	☐	☐	Is there a completed medication consent in the chart for each medication at least once?
☐	☐	☐	Are the appropriate medications prescribed for the diagnosed condition or clinical situation?
☐	☐	☐	Are the medications prescribed at doses consistent with the BHRS FDA Guidelines for Indications and Dosage Ranges? https://www.smchealth.org/sites/main/files/file-attachments/medconsentdosagerange.xlsx
☐	☐	☐	If the dose is outside the FDA recommended range, does the medication consent cover the current dose, and has the clinician documented the reasons for the dose?
☐	☐	☐	If multiple medications in the same class are used, are the reasons documented (e.g., is the rationale for two antipsychotics or two antidepressants in the chart)?
☐	☐	☐	Is there documentation that the clinician evaluated client's adherence to the treatment regimen?
☐	☐	☐	Is there documentation that the prescriber has regularly and at least annually asked the client about the presence of adverse side effects of medications?
☐	☐	☐	If there are or were adverse reactions, is there evidence of clinical response to the reactions such as a change in medications or the addition of a medication to treat side-effects?
☐	☐	☐	Is there documented evidence of assessment of drug interactions?
☐	☐	☐	Is there documented evidence that the clinician has evaluated the response to treatment and indicated the estimated degree of improvement?
☐	☐	☐	If there was a limited response to the medication, was the dose adjusted or the medication changed appropriately?
☐	☐	☐	If the client has been on the same medication(s) for any length of time, is there evidence that the clinician has assessed the continued appropriateness of the medications(s) or made dose adjustments?
☐	☐	☐	If an antipsychotic medication (first or second generation) or a VMAT-2 inhibitor is prescribed, is there an AIMS exam in the chart within the last 12 months?
☐	☐	☐	In the last year, have client concerns about medications, and updated discussions regarding any newly understood risks, benefits, or side effects been documented?

4. Controlled substance prescribing

☐	☐	☐	If a controlled substance is prescribed, is there documentation that the clinician has assessed for potential misuse or diversion? Examples: notations of checking CURES (checking CURES is required at the time of initial prescribing and every six months thereafter for all controlled substance prescriptions) or discussing why misuse or diversion would be unlikely.
☐	☐	☐	If a benzodiazepine or "z-drug"* has been prescribed, has the clinician documented the reasons for the need for using that agent instead of a non-controlled medication? * Z-drugs include zolpidem, eszopiclone, and zaleplon.
☐	☐	☐	If there is a risk of opioid use or overdose, has the provider offered naloxone (e.g., prescribed naloxone or documented recommendations to get naloxone)? (California AB2760 requires prescribers to offer naloxone if the patient takes a benzodiazepine and an opioid concurrently.)

5. Laboratory Monitoring

Yes	No	N/A	
☐	☐	☐	Was appropriate lab work obtained (either by new labs or confirmation of prior labs) and documented before or at the time of starting medications? Examples including lipids panel and HGA1C for antipsychotics, creatinine and TSH for lithium, and liver panel and platelets for valproic acid.
☐	☐	☐	If the medication(s) used requires ongoing lab monitoring, has that lab work been obtained and documented in a proper time frame?
☐	☐	☐	• If no to the above question, has the clinician documented that they have encouraged lab testing, and explained the risks and consequences of not getting labs done?

6. Connection to Primary Care

Yes	No	N/A	
☐	☐	■	Is there documentation that the client already has a primary care provider, or documentation that the clinician has attempted to connect the client with a primary care provider?

7. Recommendations

Steps after completing 1-7 above:

1. Reviewing Physician / NP signs and dates here:	
2. Reviewing Physician / NP sends to the Treating Physician / NP.	
3. Treating Physician / NP reviews this form.	
4. Treating Physician / NP writes a response to the review and/or recommendations here:	
5. Treating Physician / NP signs and dates here:	
6. Treating Physician / NP sends this form to supervisor (usually a Med Chief).	
7. Med Chief collects all forms and sends to Medical Director for review.	
8. Date received by Medical Director (or Designee) goes here:	