Clear form

Addendum B
Psychotropic Medication / Behavior Support Plan

◯ Psychotropic Medication Plan ◯ Behavior Support Plan ◯ Both

Name:

Do not complete this section if this is a Behavior Support Plan only

Psychiatric Diagnosis:

Current Psychotropic or other Medication to manage behavior(s) *(including benefits/side effects)*: *See informed consents*

Behavior(s) related to the diagnosis:

Staff Response to Side Effects:

Psychotropic or other medication to manage behaviors will be considered for reduction when:

Targeted Behaviors over the last year or since the last review:

- Obtain incident reports and behavior data
- For each month describe the behaviors that occurred and how many times

Targeted Behaviors	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec

Indicate safeguards to minimize risk which the team feels are necessary to ensure the individual is free from unnecessary risk related to the medication. This may include information such as: How the medication is stored, who is monitoring for side effects, and who is administering the medications.

List measures previously tried to manage behaviors and how the individual responded.

List any restrictive interventions being used to manage behavior(s).

What purpose does the behavior(s) serve *(ex. Attention seeking/way of communicating)*?

What may trigger the target behavior(s)?

Describe how staff is to respond to the individual when a target behavior(s) is observed.

Describe the desired behavior(s) to replace the targeted behavior above.

Describe how staff will support the individual to reinforce the desired behavior(s).

List any materials staff need access to in order to effectively implement this plan. *(Environmental Modifications Considered)*

How will behavior data be collected and by whom?

Describe the risks, benefits, and/or side effects of the restrictive intervention being used?

If an individual is taking psychotropic or other medications to manage behavior or treat a diagnosed mental illness and / or if an individual has restrictive interventions, a Behavior Management Committee review will be completed.

By signing below, I agree to the medication and/or restrictive interventions explained above and give approval for this plan to be implemented.		
Printed Name	**Signature**	**Relationship to Person**

Efforts to Obtain Participation of Guardian(s), Support Team Members, etc.:

Documented Attempts - *example USPS, phone, in person, through email*

How was the attempt made?	Date of Attempt	Initials