



Tennessee Department of Children's Services  
**Psychotropic Medication Evaluation**

**Note: Complete this form at every medication evaluation appointment. Healthcare Providers may prefer to provide their own documentation regarding information contained in this form.**

**If new psychotropic medication is prescribed an Informed Consent must be signed and forwarded to the DCS Health unit.**

Appointment date \_\_\_\_\_ TFACTS person ID# \_\_\_\_\_

Child's name \_\_\_\_\_ DOB \_\_\_\_\_

Home County \_\_\_\_\_ FSW name \_\_\_\_\_

Provider name \_\_\_\_\_ Phone # \_\_\_\_\_

Clinic name \_\_\_\_\_

Address \_\_\_\_\_

DSM-V Diagnosis \_\_\_\_\_

Symptoms \_\_\_\_\_

Other Treatments \_\_\_\_\_

Current and discontinued medications (name, dose, frequency, route, and # of refills)

#1 \_\_\_\_\_ # of Refills \_\_\_\_\_

Increase  Decrease  Discontinued  No change  New

# 2 \_\_\_\_\_ # of Refills \_\_\_\_\_

Increase  Decrease  Discontinued  No change  New

# 3 \_\_\_\_\_ # of Refills \_\_\_\_\_

Increase  Decrease  Discontinued  No change  New

# 4 \_\_\_\_\_ # of Refills \_\_\_\_\_

Increase  Decrease  Discontinued  No change  New

# 5 \_\_\_\_\_ # of Refills \_\_\_\_\_

Increase  Decrease  Discontinued  No change  New

Reason medication stopped? \_\_\_\_\_

Reason for changes? \_\_\_\_\_

Recent Height: \_\_\_\_\_ Recent Weight: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_

Laboratory tests?  No  Yes (specify) \_\_\_\_\_

Other diagnostic tests?  No  Yes (specify) \_\_\_\_\_

Next appointment \_\_\_\_\_

Provider signature \_\_\_\_\_ Date \_\_\_\_\_

Check the "Forms" Webpage for the current version and disregard previous versions. This form may not be altered without prior approval.  
 Distribution: SAT Coordinator, Child/Youth's Case File, Health Record