|  |
| --- |
| **NAME OF BSC, WITH CREDENTIALS****NAME OF BSC AGENCY****CITY, NEW MEXICO****PHONE CONTACT; FAX CONTACT****EMAIL ADDRESS** |
| **PRN PSYCHOTROPIC MEDICATION PLAN****TIME PERIOD** |
| **INDIVIDUAL’S NAME:** |  | **JACKSON CLASS MEMBER:** |  |
| **DOB:** |  | **LAST 4 OF SSN:** |  |
| **INDIVIDUAL’S ADDRESS:** |  | **INDIVIDUAL’S PHONE CONTACT:** |  |
| **GUARDIAN:** |  | **GUARDIAN CONTACT:** |  |
| **RESIDENTIAL AGENCY:** |  | **CCS AGENCY:** |  |
| **CASE MANAGER:** |  | **CASE MANAGER AGENCY:** |  |
| **OTHER PROVIDERS:** |  | **REGION OF RESIDENCE:** |  |
| **ANNUAL ISP DATE:** |  | **DATE OF REPORT:** |  |
| 1. **MEDICATION INFORMATION**
	1. Name of Prescribed Medication
	2. Medication Dosage
	3. Reason Prescribed
2. **PRESCRIBING PHYSICIAN**
	1. Doctor’s Name
	2. Doctor’s Location
	3. Doctor’s Phone Contact
3. **BEHAVIORAL INDICATORS OF ESCALATION/AGGITATION**
	1. Describe what the individual is doing
4. **BEFORE ASSISTING WITH MEDICATION**
	1. List strategies that can be used to calm individual down
	2. Refer to BCIP
5. **CONSIDER CONTACTING NURSE REGARDING PRN MEDICATION IF:**
	1. List specific indicators based on the individual’s escalation pattern
6. **ASSIST WITH PRESCRIBED DOSAGE OF PRN MEDICATION IF:**
	1. The above circumstances have been met or another equally serious set of events is in motion; AND.
	2. You have followed any/all other guidelines of YOUR RESIDENTIAL AGENCY’S NURSING PLAN which may include calling the agency nurse for final approval prior to administration.
7. **PLEASE NOTIFY THE BSC OF ANY/ALL PRN USAGE**
 |
| **BSC SIGNATURE***WITH TITLE AND CREDENTIALS* | **DATE** |

**Please Note: In many/most cases these plans are best written in conjunction with the agency nurse and co-signed by the same.**