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| **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.**