Name:

D.O.B:

Antipsychotic and Dementia Medication Monitoring Record Booklet

An anti-psychotic medication is being prescribed to this individual for symptoms associated with a dementia.
This medication should be reviewed on a 3-monthly basis. At each review, **consideration should be given to** a reduction in or discontinuation of the drug.

The medication reviews may be undertaken by primary or secondary care

Antipsychotic Medication

Risperidone	Olanzapine	Aripiprazole	Chlorpromazine
Quetiapine	Amisulpride	Haloperidol	Promazine

Flupentixol injection (Depixol)
Fluphenazine injection (Modecate)
Haloperidol Injection (Haldol)
Risperidone injection (Risperdal)
Zuclopentixol injection (Clopixol)

Dementia Medication

Donepezil	Galantamine	Memantine	Rivastigmine

Antipsychotic / Dementia Initiation

NAME: ……..... DATE OF BIRTH:……/……/……

Place of medication being commenced: ……

Reason for prescribing antipsychotic:

Target symptoms (especially distress), severity & risk of harm to self or others:

Other approaches tried (including medications):

Consider physical health review/pain/infection/depression:

Current psychotropic medication:

NB. Especially benzodiazepines

Capacity:

Capacity to consent to medication	yes ( )	no ( )
Discussion with patient if appropriate	yes ( )	no ( )
Best interest decision made (discussion with family/carer and staff)	yes ( )	no ( )
Patient/carer information leaflet given	yes ( )	no ( )

- Anti-psychotic prescribed (state starting dose): ……

If **not** risperidone, state rationale for drug choice: ……

- **Date commenced**: …… **Planned review:** ……
- Signature (and designation): ……

Antipsychotic / Dementia Review Record

NAME: ……..... DATE OF BIRTH……/……/……

Place of medication review: ……

Date of review		
Current psychotropic medication (especially benzodiazepines)		
Patient seen? (Y/N)		
Any side effects? (describe)	Sedation/ weight gain	
	Parkinsonian effects	
	Poor posture, mobility, falls	
	Cognitive side-effects	
	other	
For how long has the drug been taken? (in weeks or months)		
Any changes in or benefit to target symptoms? (description of current presentation)		
Outcome of review (include **name and dose** of drug)	eg. continue/stop /trial off/ restart/ change dose /change drug	
With whom has the outcome been discussed?		
Next planned review (in weeks or months)		

- Signature (and designation): …….

Antipsychotic / Dementia Review Record

NAME: ……..... DATE OF BIRTH: ……/……/……

Place of medication review: ……

Date of review		
Current psychotropic medication (especially benzodiazepines)		
Patient seen? (Y/N)		
Any side effects? (describe)	Sedation/ weight gain	
	Parkinsonian effects	
	Poor posture, mobility, falls	
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Outcome of review (include **name and dose** of drug)	eg. continue/stop /trial off/ restart/ change dose /change drug	
With whom has the outcome been discussed?		
Next planned review (in weeks or months)		

- Signature (and designation): …….

Antipsychotic/Dementia Medication Log

Care Home:	Resident:	D.O.B.

Date	Medication	Dose	Changed to	Prescriber	Reason

Antipsychotic/Dementia Medication Log

Care Home:	Resident:	D.O.B.

Date	Medication	Dose	Changed to	Prescriber	Reason