Balancing Test Form for I/DD Resident			
Resident Name:	Operator Name:		
Medication Name(s):	Date Ordered:		
Physician Name:	City:	State:	Zip Code:

Multnomah County Administrative Rule 023-120-565 and 023-090-225

1. **Requirements:** Psychotropic Medications and medications for behavior must be:
   (a) Prescribed by physician or health care provider through a written order; and
   (b) Monitored by the prescribing physician, ISP team and program for desired responses and adverse consequences.
2. **Balancing test:** When medication is first prescribed and annually thereafter, the provider/operator must obtain a signed balancing test from the prescribing health care provider using this Balancing Test Form. Provider/Operator must present the physician or health care provider with a full and clear description of the behavior and symptoms which need to be addressed, as well as any side effects observed.
3. **Documentation requirements:** The provider/operator must keep signed copies of these Form(s) in the resident's medical records for seven (7) years.

Service Provider:

Does the resident have a formal behavior program? ☐ Yes ☐ No

Date of visit when health care provider last prescribed psychotropic medication:________________________

Briefly describe behavioral trends since last visit. (Has there been increase, decrease or no change? Include frequency data if applicable. Attach graphs or summary of behavioral incidents if available,) ______________

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Any side effects of the medication observed? Briefly describe: ____________________________________

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Environmental or other factors believed to impact behavioral data presented (staff changes, illness, etc,) Briefly describe: ____

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Describe the behavior and its potentially harmful effects:____

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Describe the potential side effects of the medication:____

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Physician and Provider/Operator Discussion:

The staff supporting this individual in the adult care home is required to report changes in frequency and/or intensity of behaviors being treated with psychotropic medications to me. As well, include any information about observed side effects, and the benefits of the prescribed medication.
Was this provided to you? Yes ○ No ○

The Federal Centers of Medicare and Medicaid (CMS) expect the judicious use of psychotropic medication in order to avoid chemical restraints. I have reviewed the information provided and believe the use of this medication is in the best interest of this individual.

Physician Signature:____

Date signed by Physician:___________________________________

Monitoring Requirements:

By ACH Operator/Provider:____

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By Physician:____

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