FLORIDA DEPARTMENT OF JUVENILE JUSTICE

CLINICAL PSYCHOTROPIC PROGRESS NOTE

NAME OF YOUTH: _____ **DOB:** _____ **DJJID#** _____

Prescribing Practitioner: _____

DJJ Facility (incl. phone number) _____

Allergies:

Chief Complaint/Clinical Symptoms

Mental Status Exam

Diagnosis (DSM-IV-TR or DSM-5 Diagnoses)

DSM-IV-TR DIAGNOSES	DSM-5 DIAGNOSES
Axis I:	
Axis II:	
Axis III:	
Axis IV:	
Axis V (GAF):	

_____
Signature of Practitioner

_____
Printed Name

NAME OF YOUTH: _____ **DJJID #** _____

This page requires completion only if an initial psychiatric diagnostic interview or psychiatric evaluation is conducted.

Past Prescribing Practitioners

Past Mental Health Diagnoses

Past Medications & Responses

Past Therapy

Past Family Psychiatric History

Medical Problems/Surgeries

Other/Personal History

Drug/Alcohol Usage

Treatment Planning Recommendations:

_____
Signature of Practitioner

_____
Printed Name

NAME OF YOUTH: **DJJID #:** **DJJ Facility:**

	*Psychotropic Medication Ordered	***Dosage & Frequency	Diagnosis/Target Symptoms	**Diagnosis/Clinical Justification	Common Side Effects	****Usual Dosage Range
1						
2						
3						
4						
5						

*Practitioner: Please write explicitly the medication regimen, even if it is unchanged from prior appointment

**Practitioner: Please provide brief rationale for each medication. If you are prescribing more than one psychotropic medication, please include a justification as to why more than one is required

*** Practitioner: If you wish to have medication increased on a specific date prior to youth's next appointment, please write as a separate order and include date of change

****Practitioner: Only list usual dosage range if prescribed dosage exceeds the dosage typically prescribed for children.

Special Instructions to Facility Staff:

Frequency of Side Effects Monitoring:
Weekly or _____ Times per week

Tardive Dyskinesia Screening:
Monthly ☐ Yes ☐ No _____ **Times per month**

Schedule laboratory or other testing: _____
Date you wish to see the youth again: _____

Laboratory/Testing Reviewed:
☐ Yes ☐ No ☐ NA

If Abnormal, actions taken:

Treatment Plan/Medications/Risk & Benefits/Alternatives Explained to:

Youth: ☐ Yes ☐ No
Parent/Guardian: ☐ Yes ☐ No
Parent/Guardian Agrees to Treatment Plan:
☐ Yes ☐ No

_____
Signature and printed name of witness to parental verbal consent Date

_____
Signature and printed name of prescribing Practitioner Date