



FLORIDA DEPARTMENT OF JUVENILE JUSTICE

CLINICAL PSYCHOTROPIC PROGRESS NOTE

NAME OF YOUTH: _____ DOB: _____ DJJID# _____

Prescribing Practitioner: _____

Allergies: _____

DJJ Facility (incl. phone number) _____ / _____

Chief Complaint/Clinical Symptoms

Mental Status Exam

Diagnosis

Axis I:

Axis II:

Axis III:

Axis IV:

GAF:

Signature of Practitioner

Printed Name



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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

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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:

Laboratory/Testing Reviewed:

Yes No NA

If Abnormal, actions taken:

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: _____

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

