Balancing Test Form

To be used when psychotropic medications are first prescribed and annually thereafter

DHS | Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

Client name: _____ Date of birth: _____

Medication name: _____

Prescribed by: _____ Date ordered: _____

Oregon Administrative Rule (411-325-0360, 411-346-0190; 411-360-0140)

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 must obtain a signed balancing test from prescribing health care provider using the DHS Balancing Test form. Providers must present the physician or health care provider with a full and clear description of the behavior and symptoms to be addressed, as well as any side effects observed.
3. **Documentation requirements:** The provider must keep signed copies of these forms in the individual's medical records for seven (7) years.

Service provider
Describe the behavior and its potentially harmful effects:
Describe the potential side effects of the medication:

Prescribing physician or health care provider discussion

The provider supporting this individual in their home is required to present me with a full and clear description of the behavior or symptoms of the condition to be treated by the psychotropic medication and information on any observed side effects. If needed, the information requested may include the frequency, intensity and circumstances around the symptoms. **Was this provided?** ☐ **Yes** ☐ **No**

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

This form is valid for up to one year following the signature date

Monitoring requirements
Physician or health care provider:
Service provider:

Signature of physician or health care provider **Date**

This form is valid for up to one year following the signature date