SPECIAL TREATMENT PLAN FOR FORCED ADMINISTRATION OF MEDICATIONS

Recipient Care Guidance Sheet

The recipient named below is hereby referred by _____to your facility for possible forced administration of medication, pursuant to a court order for involuntary treatment issued by the Maricopa County Superior Court. The information on this form is intended to provide guidance for medical providers external to our clinic, who must use their independent clinical judgment in evaluating and treating this recipient. Additional information regarding the response of this recipient to psychiatric medications may exist in other records that may not be available to our clinic. Forced medication should be used only after less restrictive treatments have been considered and should be used in a manner consistent with the Arizona Administrative Code Title 9 Chapter 21, the requirements of accrediting bodies where applicable and the court order issued for this recipient.

Name: _____ CIS ID:_____ DOB:_____

Clinic Name: _____ Phone:_____

Gender (circle one): Male Female Other

Last Known Address: _____

_____

Other Insurance [Plan ID numbers and contact phone]:_____

Below to be completed by Provider

So

Name of Provider And Credentials: _____

_____**Phone:**_____

Current COT please check all that apply PAD DTO DTS GD

COT start date : _____**Expiration Date:**_____**Mental health Case #**_____

Treating Provider: (Name) _____ **Phone:**_____

Info: ___ Same BHMP

Clinic Case Manager: _____ Phone: ☐cell ☐office_____

Med/Food Allergies: _____

Diagnoses: _____

1. How will the recipient's condition be expected to improve through the use of forced medications?

☐ Decrease paranoia ☐ Decrease agitation ☐ Reduce aggressive behaviors ☐ Prevent further deterioration

☐ Reduce hallucinations/psychosis ☐ Reduce mania ☐ Reduce suicidal ideation/behaviors

☐ Reduce deliberate self-harm ideation/behaviors ☐ Other_____

2. What medications can be clinically considered by the inpatient medical provider for forced administration? List medication(s) and suggested dosages:

The actual medications and dosages given to the recipient are determined by the inpatient medical provider treating the recipient at your facility based on current clinical presentation and available history.

IF THE PATIENT REFUSES PO MEDICATIONS, THEN THE FOLLOWING IM ALTERNATIVES CAN BE GIVEN PER THE STP:

Short-acting injectables:

☐ Haldol 5 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours; if tolerated, consider Decanoate

☐ Haldol 10 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours; if tolerated, consider Decanoate

☐ Prolixin 5 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours; if tolerated, consider Decanoate

☐ Prolixin 10 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours; if tolerated, consider Decanoate

☐ Geodon 10 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours

☐ Zyprexa 10 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours

☐ Thorazine 25 mg IM Q1 -6 hrs PRN, not to exceed 4 doses in 24 hours

☐ Thorazine 50 mg IM Q1-6 hrs PRN, not to exceed 4 doses in 24 hours

☐ Thorazine 100 mg IM Q1 to 6 hrs PRN, not to exceed 4 doses in 24 hours

☐ Ativan 1 mg IM Q1-6 hrs PRN agitation not to exceed 4 doses per 24 hours

☐ Ativan 2 mg IM Q1-6 hrs PRN agitation not to exceed 4 doses per 24 hours

Long-acting injections:

☐ Risperdal Consta IM as long as patient has tolerated the PO formulation

☐ Invega Sustenna IM as long as patient has tolerated the PO formulation

☐ Invega Trinza IM as long as patient has tolerated the PO formulation

☐ Abilify Maintenna IM as long as patient has tolerated the PO formulation

☐ Aristada IM as long as patient has tolerated the PO formulation

☐ Haldol Decanoate IM as long as patient has tolerated the PO formulation

☐ Prolixin Decanoate IM as long as patient has tolerated the PO formulation

☐ Other: _____

_____

If the recipient is receiving a recurring injectable medication, please verify the last injection date before administering)

3. **Has the recipient ever received the medications recommended in question #2 before?** _____

4. **If so, which ones?**_____

5. If side effect medications are necessary, please indicate which of the following are suggested:

☐ Cogentin IM/PO or Benadryl IM/PO

☐ Ativan 1 mg po/IM Q1-6 hrs PRN side effects not to exceed 4 doses per 24 hours

☐ Ativan 2 mg po/IM Q1-6 hrs PRN side effects not to exceed 4 doses per 24 hours

The side effect medications and dosages given to the recipient are determined by the inpatient medical provider treating the recipient at your facility based on current clinical presentation and available history

6. If there are special circumstances, ie pregnancy, medically compromised, geriatric, what has been tried and failed and what is the outpatient team's medication recommendation? _____

These medication recommendations above may not accurately reflect the prescribed regime given to the patient on an outpatient basis as part of their routine care. The inpatient medical provider treating the recipient at your facility is expected to exercise independent clinical judgment in determining the treatment necessary for this recipient.

This Special Treatment Plan for Forced Administration of Medication requires an update every 3 months. The last update for this plan was _____.

_____	_____	_____
Referring BHMP	BHMP signature	Date