[**Significant Medication Change Letter with Safety Plan**](https://www.oregon.gov/prb/Documents/Major_Change_in_Treatment_or_Psychiatric_Stability_2019.pdf)

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| Please submit in PDF format to [FileCloud](https://psrb.filecloudonline.com/ui/core/index.html?mode=upload&secure=1#/SHARED/%212i3dgR2ZVDurw/LSzXUfi1tqmdfwrG), without signature lock and named as:  XXXX-XX-XX Last Name, First Name, Med Change Ltr | | | | | |
| **Client:** Click or tap here to enter text. | | | | **Date:** Click or tap to enter a date. | |
| **Case Monitor:** Click or tap here to enter text.  **Case Monitor Phone:** Click or tap here to enter text. | | | | **Agency:** Click or tap here to enter text. | |
| **Level of Care**  SRTF/ECF  Semi/AFH/ICM  RTH/RTF  Independent | |
| **Licensed Medical Provider:** Click or tap here to enter text. | | | |
| **How Long at Level of Care:** Click or tap here to enter text. | | | |
| **List Each Medication Change** | | **Current Dosage(s)** *N/A if new* | | **New Dosage(s)** | **Estimated Start Date** |
| Click or tap here to enter text. | | Click or tap here to enter text. | | Click or tap here to enter text. | Click or tap here to enter text. |
| **Explain the purpose of the medication change and the factors driving or influencing the decision to change medication** | | | Click or tap here to enter text. | | |
| **Are further adjustments anticipated in the near future?** | | | **No**  **If yes, please include an anticipated timeline with dosage:** Click or tap here to enter text. | | |
| **Identify key warning signs of decompensation that both clients and staff should closely monitor.** | | | Click or tap here to enter text. | | |
| **Estimate the anticipated timeframe for monitoring signs or symptoms of decompensation should the medication change(s) be ineffective** | | | Click or tap here to enter text. | | |
| **Please describe the safety plan measures that will be implemented during this period.** | | | Click or tap here to enter text. | | |
| **At what level of care (LOC) will this medication change occur?** | | | **Current LOC  Higher LOC** | | |
| **List any psychotropic medications (which are not** **changing.** | | | Click or tap here to enter text. | | |
| **Check any safeguards that will be in effect.** | Increased staff contact to monitor changes in psychiatric symptoms or mental status.  Staff/Client will track psychiatric symptoms on a symptom tracking log.  Follow-up with Licensed Medical Provider as needed.  Limitations will be implemented regarding the client’s pass program or level system. | | | | |
| **Please attest to the following** | | | | | |
| **LMP reviewed the PSRB exhibit file and is aware of medication history and risk profile.**  **LMP consulted with the PSRB case monitor and other members of the treatment team.**  **All members of the treatment team (& client) are aware of the medication change and informed of the safety plan.**  **LMP follow up is scheduled.** | | | | | |

