



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 (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

FLORIDA DEPARTMENT OF JUVENILE JUSTICE

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

**FLORIDA DEPARTMENT OF JUVENILE JUSTICE**

	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