MONITORING FOR PATIENTS ON SGAs: (Second Generation Antipsychotics)

Patient identification

(Circle medication prescribed):

ABILIFY™	CLOZARIL™	GEODON™	RISPERDAL™	SEROQUEL™	ZYPREXA™
(Aripiprazole)	(Clozapine)	(Ziprasidone)	(Risperidone)	(Quetiapine)	(Olanzapine)

DATE SGA MEDICATION WAS STARTED: _______________

DATE OF ADMISSION TO BRENTWOOD: __________ DATE OF DISCHARGE FROM BRENTWOOD: __________

The following baseline history was obtained during the patient's admission to the hospital:

PERSONAL/FAMILY HISTORY: (circle)			IF YES: WHO AND NATURE OF PROBLEM:
Obesity	yes	no	
Diabetes	yes	no	
Dyslipidemia- (elevated cholesterol or triglycerides)	yes	no	
Hypertension	yes	no	
Cardiovascular Disease	yes	no	

The following baseline information was obtained during the patient's admission to the hospital:

Weight (pounds): _______

Waist Circumference (inches): _________

Blood Pressure: ________

Fasting Labs: _________ **(date completed)**

Glucose: _________

Lipid Profile:

Cholesterol: ______

Triglyceride: ______

The following monitoring protocol is recommended by the American Diabetes Association:

MONITORING PROTOCOL FOR PATIENTS ON SGAs: (the X indicates when the monitoring is indicated)

	Baseline (see above)	4 weeks	8 weeks	12 weeks	Quarterly	Annually	Every 5 years
Personal/family history	X					X	
Weight	X	X	X	X	X		
Waist Circumference	X					X	
Blood Pressure	X			X		X	
Fasting plasma glucose	X			X		X	
Fasting lipid profile	X			X			X

PRIMARY CARE PHYSICIAN OR OTHER PROVIDER: ______________________________

TELEPHONE NUMBER: ______________________________

DATE OF FOLLOW UP APPOINTMENT: ______________________________

I authorize Brentwood Behavioral Healthcare of MS to release a copy of this form to my primary care physician or other healthcare provider who will provide the follow-up monitoring recommended. I acknowledge that the hospital staff has counseled me regarding the recommended follow- up monitoring and I have received a copy of this form. I also understand that I am responsible for taking a copy of this form to my follow up appointment for the monitoring recommended above.

____ _____________ _________________________

Signature of patient or legally authorized decision maker   Date   Witness signature

MEDICAL RECORDS USE ONLY: Date: _____________ Mailed _______ Faxed _______

To: Primary care physician: ________

Other (specify): _____________

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