

 <p style="text-align: center;">County of Sacramento Department of Health and Human Services Division of Behavioral Health Services Policy and Procedure</p>	Policy Issuer (Unit/Program)	QM
	Policy Number	QM-07-02
	Effective Date	04/19/1996
	Revision Date	08/01/2020
Title: Medication Monitoring		Functional Area: Interface with Physical Health Care
<p>Approved By:</p> <p>Alexandra Rechs, LMFT Program Manager, Quality Management</p> <p>Glen Xiong, MD Medical Director, Sacramento County Behavioral Health Services Center</p> <p>Robert Horst, MD Medical Director, Child and Family Services</p>		

Background/Context:

Medication Monitoring falls under the umbrella of quality improvement monitoring in psychiatry. As defined in the Manual of Psychiatric Quality Assurance: “The goal of quality assurance is to ensure that the important aspects of medical care are delivered in accordance with pre-established standards of acceptable medical practice.”

The quality improvement process under the Sacramento County Division of Behavioral Health Services (DBHS) mandates that each contracted or county operated program shall include in their Quality Improvement Plan at least the following components: 1) Utilization Review; 2) Medication Monitoring; and 3) Peer Review. The Medication Monitoring Committee has been established to meet the County objectives, as well as State mandates in quality improvement for medication monitoring.

Purpose:

The intended purpose of medication monitoring is to establish a process to promote the appropriate use and management of psychotropic and other medications. Systematic monitoring is intended to meet the following objectives:

1. Monitor and promote the safe and effective use of psychotropic medications;
2. Reduce the inappropriate use of medications;
3. Promote the proper prescribing and monitoring of psychotropic agents by the prescriber;
4. Monitor medication adherence and informed consent;
5. Improve quality of medication services by monitoring of appropriate documentation to reduce the risk of adverse drug reactions through proper documentation of side effects, adherence and response to medications and also regular lab work and EKG'S when necessary

To achieve these ends, the Medication Monitoring Committee uses evidence based practices and approved criteria developed by the County Pharmacy and Therapeutics (P&T) Committee to assess various aspects of the treatment process. Through informational and corrective feedback to the providers, the goals for quality care can be attained.

Details:

A. Medication Monitoring Committee

The Medication Monitoring Committee is a multi-disciplinary committee comprised of Adult and Child specific committees which meet bi-monthly to review professional practices involving medication treatment for inpatient (Sacramento County Mental Health Treatment Center - MHTC) and outpatient (Integrated Services Agency - ISA, Regional Support Teams - RST Clinics, and Children Mental Health Service Contracts) populations. This committee is formulated and regulated by the procedures set forth in the MHP contract with Department of Health Care Services

Under the County Quality Assurance and Performance Improvement (QAPI) Plan, the Medication Monitoring Committee reports to the County Quality Improvement Committee.

The Medication Monitoring Committee is made of medical, nursing and clinical staff. Representatives from the outpatient programs are invited to attend meetings. The core of the committee members is comprised of the County Medical Director, a Quality Improvement representative and the Medication Monitoring Pharmacist. Participation and attendance at the medication monitoring meetings is open to all program representatives.

The administration of the Medication Monitoring Committee shall be the responsibility of the Quality Management Program Manager. The Medical Director shall chair the Medication Monitoring Committee meetings and be responsible for review of psychiatric and medical practices. The Medication Monitoring Pharmacist shall be responsible for reporting medication monitoring findings in committee meetings, and for submitting a summary report to the Quality Management Program Manager.

B. Audit Requirements

A structured medication monitoring "Screening Criteria and Compliance " audit tool, approved by the Pharmacy & Therapeutics Committee (P&T) is utilized at each audit. (See Attachment I). The Medication Monitoring Committee reviews the tool and screening criteria periodically and when necessary, based on current evidence based practices, presents its concerns for criteria changes to the P&T Committee.

Ongoing audits are conducted at each outpatient program and at the Mental Health Treatment Center where medication services have been provided. Medication audits will utilize the "Screening Criteria and Compliance" tool whose explanation is found in the "Medication Monitoring Criteria Explained" (attachment 2). Audits will follow the "Medication Monitoring Standards and Guidelines," which is a separate set of written guidelines for the purpose of chart audits. The minimum chart sample size for audit can be determined by the Behavioral Health Adult or Children's Services Medical Director if special circumstances require to increase number of charts. These special circumstances may include but are not limited to: State/Federal audit requests, plans of correction, program improvement projects

focusing on medical services, or other legitimate concerns which can potentially arise requiring to audit more charts beyond the 5%. This number, however, cannot fall below five percent (5%) annually. Agencies will be asked to randomly select from active cases in order to obtain the required minimum standard. The number of charts reviewed at the Mental Health Treatment Center will be at least 5% of the average monthly admissions computed on an annual basis. .

C. Meetings

Medication Monitoring Committee meetings are held bimonthly at the Sacramento Mental Health Treatment Center on even numbered months (February, April, June, August, October, December) Announcements of upcoming meetings will be sent out by the Medication Monitoring Pharmacist at least a week ahead of the scheduled meeting to committee members and to all programs whose audit findings will be presented. It is highly recommended that representatives from the programs being audited are in attendance for the reporting of their specific audit findings.

The Medication Monitoring Pharmacist is responsible for taking minutes to document the activities and outcomes of the meeting.

D. Reporting and Corrective Actions

The Medication Monitoring Pharmacist presents audit findings at the Medication Monitoring meetings. The Medication Monitoring Committee collectively decides on whether any corrective measures need to be taken based on audit findings. In the event a correction is required, the Medication Monitoring Pharmacist, with approval from the Chair of the Medication Monitoring Committee, sends a corrective memo of notification to the program. This is sent to the programs' Medical Director, Program Director, Program Manager and Clinical Director. The memo will outline the specific corrective measures for which a response is expected. An acknowledgement of the receipt of the corrective memo is expected within 30 days. The program manager will be responsible for taking the necessary corrective actions, which should be reported to the Medication Monitoring Pharmacist who is required to report outcome back to the Medication Monitoring Committee at the next meeting. If resolution is unattainable, it can be referred to the Committee for further review or investigation.

In addition, each program's audit report will be mailed to the program and is to be reviewed by the Physician, Physician Assistant (PA), Nurse Practitioner (NP), Clinic Director and Program Manager and documented on the "Signature Statement" (see Attachment 3). The signed signature statement is the Medication Monitoring Committee's way of obtaining verification that the program is in agreement with the outcome of the audit findings. The Signature Statement is to be returned to the Medication Monitoring Pharmacist and will be kept in a binder with the programs' corresponding audit findings.

Copies of all audit findings from both Adult and Child/Adolescent programs are sent to the appropriate contract monitors. The Quality Management Program Manager receives copies of both Child/Adolescent and Adult Outpatient audit findings.

After approval of minutes by the Medical Directors of Child/Adolescent and Adult Outpatient, the Medication Monitoring Pharmacists distributes minutes to all committee members and programs. The minutes will also be sent to the County Quality Improvement

Committee. Where errors have been identified, a copy of the corrective measures and outcomes shall be filed in the same binder with the programs' corresponding audit reports and another copy will be filed with the minutes. Responses to corrective memos will be reported back to the Medication Monitoring Committee at the next meeting.

E. Thresholds

The thresholds for the medication monitoring criteria are implicit to meet 100%, but less than 100% does not necessarily imply substandard care. It may warrant further investigation or review.

Reference(s)/Attachments:

Attachment 1- Medication Monitoring tools

Attachment 2- Explanation of Medication Monitoring Criteria

Attachment 3- Medication Monitoring Signature Statement

Related Policies:

- Informed Consent for Psychotropic Medication QM-10-32
- Medication Support Staff Electronic Documentation Requirements QM-00-06

Distribution:

Enter X	DL Name	Enter X	DL Name
X	Mental Health Staff	X	Children's Contract Providers
X	Mental Health Treatment Center	X	Alcohol and Drug Services
X	Adult Contract Providers		

Contact Information:

Quality Management Information
QMInformation@saccounty.net

(Attachment 1)

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES DIVISION OF MENTAL HEALTH

ADULT MEDICATION MONITORING

Agency.....Date.....

AgeGender.....

Chart#.....Initials.....

Physician.....Reviewer.....

DSM-5 Diagnoses.....

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Medications.....

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Screening Criteria and Compliance	Yes	No	N/A	#	%
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1. Is there documentation of hx of drug & /or food allergies or contraindications in Order Connect?	_____	_____	_____	_____	_____
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2. For female clients of child bearing age, was pregnancy addressed in progress notes at each physician encounter? Reasons for N/A (including postmenopausal) can be endorsed in AMSP.	_____	_____	_____	_____	_____
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3. Is the dosage level within the FDA or community accepted ranges?	_____	_____	_____	_____	_____
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4. Is there documented rationale for use of community accepted dose ranges?	_____	_____	_____	_____	_____
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5. Justified use of 2 drugs in same class excluding antidepressants, Trazodone and mood stabilizers?	_____	_____	_____	_____	_____
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6. Justified use of 4 or more psychotropics?	_____	_____	_____	_____	_____
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7. Is there a valid, signed and dated, informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, refusal of meds) _____
8. Is there documentation of presence or absence of side effects in each progress note? _____
9. Is there documentation of response to current medications in each progress note? _____
10. Is there documentation of rationale for changes in medication or dose? _____
11. Is there documentation of adherence to medications in each progress note? _____
12. Has the client been seen by the provider quarterly or 3x/yr. if stable? (or has client on NP medication panel been seen by psychiatrist annually?) _____
13. When a psychotropic medication was added or discontinued, was there progress note documentation for follow up w/in 4-6 weeks, either face to face with medical or nursing staff or via phone? _____
14. If on antipsychotics, is the presence or absence of TD documented annually in an AIMS, AMSP or at least biannually in progress notes? _____
15. Are labs ordered to initiate/monitor drug therapy where indicated?
- a. Lithium-Baseline + annual CBC, SCr or BUN, TSH & levels, EKG
If ≥ 50 years of age & electrolytes if necessary _____
 - 1. Weight-baseline + annual _____
 - b. Depakote/Tegretol-Baseline & annual CBC, LFTs & levels
1. Weight-baseline + annual _____
 - c. Other: Clozaril-ANC (in addition to below)
Atyp Antipsychotic (Baseline + 1 x/yr.)
HbA_{1c} /Fasting Glucose (Baseline+annual) -Cholesterol (Baseline + annual) -Triglycerides (Baseline + 2 x/yr.) -Weight _____
 - d. Topamax-(C02) on electrolyte panel, baseline, at 3 months + annual _____
 - e. Trileptol-Na⁺ (baseline, at 3 months +annual) _____
 - f. Lamictal (see dosing protocol) _____
16. Current labs in chart (within the year) _____

Revised 12/8/17

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH

ADULT MEDICATION MONITORING
CRISIS RESIDENTIAL

Agency.....Date.....

AgeGender.....

Chart#.....Initials.....

Physician.....Reviewer.....

DSM-5 Diagnoses.....

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Medications.....

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Screening Criteria and Compliance **Yes** **No** **N/A** **#** **%**

1. Is there documentation of hx of drug & /or food allergies or contraindications in Order Connect? _____

2. For female clients of child bearing age, was pregnancy addressed at least in a single progress note? Reasons for N/A (including Postmenopausal) is required. _____

3. Is the dosage level within the FDA or community accepted ranges? _____

4. Is there documented rationale for use of

community accepted ranges?	_____	_____	_____	_____	_____
5. Justified use of 2 drugs in same class excluding antidepressants, Trazodone, and mood stabilizers?	_____	_____	_____	_____	_____
6. Justified use of 4 or more psychotropics?	_____	_____	_____	_____	_____
7. Is there a valid, signed and dated, informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, refusal of meds).	_____	_____	_____	_____	_____
8. Is there documentation in progress note of presence or absence of side effects?	_____	_____	_____	_____	_____
9. Is there documentation in progress note of response to current medications?	_____	_____	_____	_____	_____
10. Is there documentation of rationale for changes in medication or dose?	_____	_____	_____	_____	_____
11. Is there documentation in progress note of adherence to medications?	_____	_____	_____	_____	_____
12. If on antipsychotics, is the presence or absence of TD documented in an AIMS, or addressed in progress notes?	_____	_____	_____	_____	_____
13. Are labs ordered to initiate/monitor drug therapy where indicated?					
a. Lithium-Baseline + annual CBC, SCr or BUN, TSH & levels, EKG If ≥ 50 years of age & electrolytes if necessary	_____	_____	_____	_____	_____
1. Weight-baseline + annual	_____	_____	_____	_____	_____
b. Depakote/Tegretol-Baseline & annual CBC, LFTs & levels	_____	_____	_____	_____	_____
1. Weight-baseline + annual	_____	_____	_____	_____	_____
c. Other Clozaril-ANC (in addition to below) Atyp Antipsychotic (Baseline + 1 x/yr.) HbA _{1c} /Fasting Glucose (Baseline+annual) -Cholesterol (Baseline + annual) -Triglycerides (Baseline + 2 x/yr.) -Weight	_____	_____	_____	_____	_____
d. Topamax-(C02) on electrolyte panel, baseline, at 3 months + annual	_____	_____	_____	_____	_____
e. Trileptol-Na ⁺ (baseline, at 3 months +annual)	_____	_____	_____	_____	_____
f. Lamictal (refer to dosing protocol)	_____	_____	_____	_____	_____
14. Current labs in chart (within the year).	_____	_____	_____	_____	_____

Revised 12/8/17

7. Is the necessity of treatment evaluated annually in AMSP complete with Client/caregiver signature? _____

Screening Criteria and Compliance **Yes/No** **N/A** **#/%**

8. Is there a valid, signed and dated, informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, refusal of meds-where applicable) _____

9. If IC is from Court, is it current (w/in 6 months of issue)? _____

10. Is there documentation of presence or absence of side effects in each progress note? _____

11. Is there documentation of response to current medications in each progress note? _____

12. Is there documentation of rationale for changes in medication or dose? _____

13. Is there documentation of adherence to medications in each progress note? _____

14. Has the client been seen by the provider at least quarterly if stable? _____

15. When a psychotropic medication was added or significantly changed, was there progress note documentation for follow up w/in 4-6 weeks?

16. If on antipsychotics, is the presence or absence of TD documented annually in an AIMS, AMSP or at least biannually in progress notes? _____

17. Are vitals documented every 3 months? (in vitals widget for AVATAR using agencies and in progress notes or similar tool for non-AVATAR users?)

BP/Pulse _____

Ht/Wt _____

BMI _____

18. Are labs ordered to initiate/monitor drug therapy where indicated (include date)? _____

a. Lithium- CBC, SCr or BUN, TSH & levels. (Baseline + annually and as clinically indicated) _____

b. Depakote/Tegretol- CBC, LFTs & levels
 Baseline + annually and as clinically indicated)

Screening Criteria and Compliance **Yes/No** **N/A** **#/%**

c. Other: Clozaril-ANC (in addition to below)
 Atyp Antipsychotic

HbA_{1c} /Fasting Glucose
 (Baseline + at 3 months +1 x/yr. thereafter)

Cholesterol
 (Baseline + at 3 months +1 x/yr. thereafter)

Triglycerides
 (Baseline + at 3 months +1 x/yr. thereafter)

d. Topamax-(CO₂) on electrolyte
 panel, baseline, at 3 months + annual

e. Trileptal-Na⁺ (baseline, at 3 months +annual)

f. Lamictal (see dosing protocol) -----

19. Current labs in chart (within the year)

Revised 12/18

SACRAMENTO COUNTY DEPARTMENT OF HEALTH SERVICES
DIVISION OF BEHAVIORAL HEALTH

Child and Adolescent Medication Monitoring

Agency: _____ Date: _____

Client's Chart Number: _____ Initials: _____

Physician: _____ Reviewer: _____

Screening Criteria for ADHD Treatment

Yes No N/A

- | | | | |
|---|-------|-------|-------|
| 1. Is the medication used for Attention Deficit Disorders or Narcolepsy? | ___ | ___ | ___ |
| 2. Is the dosage level within the generally accepted AACAP accepted ranges? (Reference American Academy of Child/Adolescent Psychiatry guidelines)?
Clonidine 0.025mg-0.4mg/day, taper when dc
Guanfacine 0.5-4mg/day | | | |
| 3. Is the necessity of treatment evaluated annually in AMSP complete with client/caregiver signature? | ___ | ___ | ___ |
| 4. No more than 2 med changes or dose increases in any 7 day period. (should we revisit the need for this criterion?) | ___ | ___ | ___ |
| 5. Explanation for use of 4 or more psychotropic medications. | ----- | ----- | ----- |
| 6. Justification for off label use? | ___ | ___ | ___ |
| 7. Is there documentation of a valid, signed and dated informed consent with all required elements fully completed? (medication, target symptoms, type, dosage and frequency ranges, method, expected duration, and refusal of meds where applicable)?
a. If IC is from Court, is it current (w/in 6 months of issue)? | ___ | ___ | ___ |
| 8. Is there documentation of food or drug allergies? (In Order Connect widget for AVATAR using agencies and progress notes or similar tool for non-AVATAR agencies)? | ___ | ___ | ___ |
| 9. Is the medication prescribed in absence of relative contraindications?
History of substance abuse
Hypertension
Symptomatic cardiovascular disease
Hyperthyroidism
History of psychosis
Pregnant or nursing
Less than 5 years old without therapy trial first

a. If relative contraindication present, is a note in the chart supporting use of medication in this patient? | ___ | ___ | ___ |
| 10. Is there documentation of presence or absence of side effects in each progress note? | ___ | ___ | ___ |
| 11. Is there documentation of response to current medication in each progress note? | ___ | ___ | ___ |
| 12. Is there documentation of client's adherence to medication in each progress note? | ___ | ___ | ___ |

13. Are vitals documented every 3 months? (in vitals widget for AVATAR using agencies and progress notes or similar tool for non AVATAR users)?

BP/Pulse _____

Ht/Wt. _____

BMI _____

14. When a new medication was started, was the client seen by a physician within 4-6 weeks? _____

a. For a dosage change, did the physician write a progress note? within 4-6 weeks? _____

15. Was the client seen at least quarterly? _____

16. Is there documentation of CURES verification prior to treatment and every four months thereafter if treatment is ongoing? _____

DSM-5 Diagnoses: _____ *Age:* _____ *Sex:* _____

Medications: _____

Comments: _____

Revised 12/18

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MENTAL HEALTH URGENT CARE CLINIC

DATE _____ CHART # _____ PT INITIALS _____ AGE _____ GENDER _____ AUDITOR _____

PSYCHIATRIC DX: _____ Provider _____

PD/SUBSTANCE ABUSE DX/MEDICAL DX _____

MEDICATIONS	NOTES

DRUG/TEST	ORDERED	Y	N	NA	AUDITING NOTES
Lithium	SCr/BUN, CBC, TSH/Lithium level-baseline				
	EKG if 50 or older				
	Level: 5-6 days after starting/dose Δ				
	Weight -baseline				
Depakote/Tegretol	CBC, LFT, Depakote level-baseline				
	Level: 3-5 days after starting/dose Δ				
	Weight-baseline				
Atypical Antipsychotic	Clozaril – ANC-baseline				
	Blood Glucose-baseline				
	Cholesterol -baseline				
	Triglycerides-baseline				
	Weight – baseline				
Topiramate	CO2 - Baseline				
Lamicatal	(refer to dosing protocol)				
Oxcarbazepine	Na-baseline				
ALL LABS	Documentation of labs recommended is required				
Pregnancy Rule Out	/OR/ Documentation of menopause				

	Y	N	NA	AUDITING NOTES
Food/drug allergies/contraindications in Order Connect				
Informed Consent(s) for Psychiatric Medications				
Doses w/in acceptable FDA or community accepted range(s)				
Receiving two or more psychotropics in the same class?				
Rationale for use of 4 or more psychotropics				
Rationale for medication/dose changes				
Documentation of side effects				
Documentation of compliance				
Documentation of Response				

(Attachment 2)

SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES DIVISION OF MENTAL HEALTH

MEDICATION MONITORING CRITERIA EXPLAINED

1. For Avatar using programs, documentation of history of drug / or food allergies or contraindications is required in AVATAR. For non-Avatar using programs, similar documentation in progress note or programs' allergy widget is required.
2. For female clients 9 years and above, documentation of pregnancy rule out is required at each encounter with provider (Physician, Nurse Practitioner and Physician's Assistant) . Reasons for not applicable such as postmenopausal or premenarche are to be endorsed in AMSP or progress notes.
3. Dosage level outside FDA ranges requires documented rationale for use for all. This includes community accepted dose ranges and off label use.
 - a. All medication use requires documented rationale. Use of medication off label requires specific documentation justifying the off label use in children. Medication use without adequate rationale will be reviewed by the medication monitoring committee.
 - b. Medication dosages exceeding FDA maximums will be reviewed by the medication monitoring committee. Specific rationale justifying the elevated dose is required.
4. Documented justification is required if client is receiving two antipsychotics.
5. Documented justification is required if client is on four or more psychotropics.
6. The necessity of treatment is to be evaluated annually in an AMSP, complete with client/caregiver and provider's signatures.
7. A valid, signed and dated informed consent, with all elements completed, is required. For any given medication, a new consent is required if the dosage range of the existing consent is outside the current prescribed dose range. Informed consents are perpetual.
8. A JV220 (application for psychotropic medications) and/or a JV223 (court approval for use of psychotropic medications) is required if client is a court dependent. JV223'S are current for up to 6 months from date of approval. For a given medication, a new application is required if the dosage range is outside the range of the original.
9. For children, are medications prescribed in the absence of relative contraindications such as history of substance abuse, hypertension, symptomatic cardiovascular disease, hyperthyroidism, history of psychosis, pregnant or nursing, less than 5 years old without therapy trial first?
10. If relative contraindication is present, is there supporting progress note documentation?
11. Documentation of the presence/absence of side effects to medications is required in each progress note.
12. Documentation of the response to medications is required in each progress note.
13. Documented rationale for changes in medication or dose is required.
14. Documentation of adherence to medications is required in each progress note.
15. Clients are to be seen at least quarterly. For adults, if client is on nursing medication panel, client is to be seen by psychiatrist annually.
16. For ADHD meds, progress note documentation for follow up within 4-6weeks is required for dosage changes and when new meds are started.

17. For child psychotropic tool, documentation is required within 4-6 weeks of start of new meds and when there is a significant change to medications.
18. For Adults, documentation is required for follow up within 4-6 weeks at the start or discontinuation of meds. Follow up can be achieved face to face with medical or nursing staff or via phone
19. If on antipsychotics, the presence or absence of Tardive Dyskinesia (TD) is to be documented annually in an AIMS, AMSP or at least biannually in progress notes. As a reminder, TD monitoring is not considered covered under "side effects" Monitoring should be evaluated separately.
20. For Children, documentation of CURES verification is required prior to treatment and every four months thereafter if treatment is continuous.
21. For Urgent care, documentation of labs recommended is required.
22. Vitals widget usage for the documentation of Height/ Weight, Blood Pressure/Pulse and BMI is required at least every 3 months for children and at baseline and annually for adults.

Laboratory Analysis

- Lithium - CBC, SCr/ BUN, TSH and levels (Baseline + at least annually for both children and adults and as clinically indicated for children) - An EKG is required if age >50.
- Valproic acid/ Carbamazepine CBC, LFT'S and levels (Baseline + at least annually for both children and adults and as clinically indicated for children).
- Other- Clozaril ANC (in addition to all required labs for antipsychotics)
- Antipsychotics- HbA1C/Fasting glucose (Baseline, at 3 months and annually thereafter for children and baseline and annually for adults)
- Cholesterol (Baseline, at 3 months and annually thereafter for children and baseline and annually for adults)
- Triglycerides (Baseline, at 3 months and annually thereafter for children and baseline and annually for adults)
- Topamax – (CO2) on electrolyte panel (Baseline, at 3 months and annually for children and baseline and annually for adults.
- Trileptal –Na+ (Baseline, at 3 months and annually for children and baseline and annually for adults)
- Lamictal (no lab monitoring required. Approved dosing protocol is to be followed)
- Current labs should be within the year.

(Attachment 3)

**SACRAMENTO COUNTY HEALTH AND HUMAN SERVICES
DIVISION OF MENTAL HEALTH**

MEDICATION MONITORING SIGNATURE STATEMENT

The Medication Monitoring audit for the month of:

has been reviewed with the following clinic staff

(Physician, NP, PA, Clinic Director, Program Manager)

Name

Date

Name

Date

Name

Date

Name

Date

Name

Date

Name

Date

Name of Clinic

Clinic Manager

Date

Please return this form to:

**Sacramento Mental Health Treatment Center Pharmacy
2150 Stockton Boulevard #541
Sacramento, CA 95817**

Mail code: 44-001