**Medication Review, Rationale, and Monthly Case Conference Form**

**Student Name:** **Student ID#:**

**DOE:** **Date of Case Conference:**

**Current Medications (Name, Dosage, Route, Frequency)**

**Licensed Wellness staff should ascertain the following information through observation and discussions with the student during clinic encounters.**

|  |  |  |
| --- | --- | --- |
|  |  | **Explain/Comments** |
| Has student demonstrated compliance with medication regime? | ☐ Yes ☐ No ☐ Partial |  |
| Have any side effects/untoward effects been reported by the student or observed by Wellness staff this month? | ☐ Yes ☐ No ☐ Unsure |  |
| Based on your observations and student reporting, is the students’ medication regime achieving the desired effects? | ☐ Yes ☐ No ☐ Partially |  |
| Medication education has been provided to the student this month to include any or all the following:☐ Review of medication administration policies and expectations☐ Information on specific medications; disease☐ Condition specific information and expected outcomes of the medication(s)☐ Student informed of the consequences of diversion, inappropriate use, losing, trading, or trying to sell their medications to others. |  |

**Staff Present (please sign and date)**

Name: Position: Date:

Name: Position: Date:

Name: Position: Date:

Name: Position: Date:

**Center Referrals Made**

☐ None ☐ CMHC ☐ TEAP ☐ Medical ☐ Counselor ☐ Nursing ☐ Off-Center Referral

**Off center appointments**

Date: To:

Phone number: Address:

☐ Kept appointment ☐ Missed appointment If missed, rescheduled to:

**Next monthly case conference scheduled for (date and time):**