# ALLIANCE FOR BEHAVIORAL AND DEVELOPMENTAL DISABILITIES

295 North Kerrwood Drive Suite 108 / Hermitage, PA 16148 / 724-346-2233

## Medical Feedback Form

☐ Community Counseling Center ☐ Sharon Regional Behavioral Health

**Name: _____** **Date: _____**

**Current Medications:**

_____

_____

_____

**Diagnosis:**

_____

_____

_____

**Reason for Continuing Medication:**

_____

_____

_____

**Medication needs to be reviewed at least every three months.**

Next Appointment: _____

Is blood work needed before next appointment? _____

Are medications within therapeutic levels? _____

**Signature of Physician:** _____ Date: _____

**Signature of Individual:** _____

**Signature of Supervisor:** _____

**Signature of Staff:** _____

*Any medication changes must be changed on the MAR immediately following this appointment by the staff person taking the appointment.