Gradual Dose Reduction Tracking Form

Facility Name: _____ **Date:** _____

Resident Name:	**Prescribing Clinician:**
Medication/Dose:	**Frequency:**
Length of Therapy:	**Diagnosis:**
Target Behavior(s):	
a) Gradual dose reduction (GDR) must be discussed at this time, and we need to attempt a GDR ***OR*** *b) Provide documentation that demonstrates continued use is in accordance with current standards of practice and any attempted dose reduction is likely to impair the individual's function OR target symptoms returned or worsened after the most recent attempt at GDR and the physician has documented the clinical rationale for why any additional attempted dose reduction is likely to impair the individual's function or increase distressed behavior.*	
Inter-disciplinary team (IDT) behavior committee has reviewed use of medication. Risk vs. benefit outline:	
☐ **Yes, please taper to the following dose:**	
☐ **No, the current medication regimen allows the resident to function at the highest practicable level of wellbeing. Reduction would be distressful to the resident and the behavior could potentially increase and may exacerbate any underlying medical and psychiatric disorder impairing the resident's overall quality of life. It is my professional medical opinion that the benefit of the medication(s) outweighs any side effects/risks involved.**	

Comments: _____

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Signature: _____ Date: _____

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