

**MONTANA MENTAL HEALTH NURSING CARE CENTER
INVOLUNTARY MEDICATION REVIEW COMMITTEE**

DATE: _____

PRESENT: _____

PATIENT NAME:		DATE OF BIRTH:	
PATIENT NUMBER:		ROOM NUMBER:	
DATE OF ADMISSION:	TYPE OF ADMISSION:		
	Involuntary	Voluntary	Guardian
DIAGNOSIS			
TYPE OF MEDICATION TO BE ADMINISTERED:			
JUSTIFICATION FOR INVOLUNTARY MEDICATION:			
WILL PATIENT ACCEPT ANY SIMILAR MEDICATION THAT MIGHT BE HELPFUL?			
HAS THE PATIENT/GUARDIAN BEEN INFORMED OF THE BENEFITS AND RISKS OF THE PROPOSED MEDICATION? If not, explain:			
ALLERGIES:			
IS THERE ANY PHYSICAL PROBLEMS THAT MIGHT BE AFFECTED IF MEDICATION IS OMITTED?			

Approved: _____ Approved with Conditions: _____ Not Approved: _____

COMMENTS: _____

COMMITTEE CHAIRMAN SIGNATURE: _____