REQUEST FOR GRADUAL DOSAGE REDUCTION (GDR)

Dr. _____, Date:_____ Time:_____ ❍ AM ❍ PM

Regarding your patient _____ DOB:_____
(Full Name)

who is receiving this psychotropic medication _____:
(Drug name, dose and frequency)

Federal regulations for long-term care facilities require that each resident's drug regimen be free from unnecessary drugs. The definition of an unnecessary drug includes any drug used for excessive duration, without adequate monitoring, without adequate indications for its use, used in the presence of adverse consequences which indicate the dose should be reduced or the drug discontinued and/or any combination of these reasons.

These regulations are part of the Centers for Medicare & Medicaid Services (CMS) regulations regarding licensing of long-term care facilities. Failure to consider gradual dose reduction could subject

_____ to citation, deficiencies and/or potential loss of licensure.
(Facility Name)

RECOMMENDATIONS BY PHARMACIST

Observations/Comments: _____

_____

_____

_____

Pharmacist Signature: _____ Date:_____ Time:_____ ❍ AM ❍ PM

RESPONSE FROM ATTENDING PHYSICIAN

Regarding the patient and medication identified above, please indicate your order for one or more of the following:

❍ Discontinue medication now. Comments: _____

_____

❍ Do not change the FREQUENCY or DOSAGE of this drug. In my professional opinion, and/or by diagnosis, to do so is clinically contraindicated*.

Physician statement regarding contraindications for GDR REQUIRED: _____

_____

_____

_____

*(By definition, clinically contraindicated in this instance refers to a patient with a documented diagnosis and that tapering of this medication would not achieve the desired therapeutic effect and that the current dose is necessary to maintain or improve the patient's function, well-being, safety and quality of life.)

❍ Taper the ❑ Frequency ❑ Dosage of this medication as follows then contact me for further instructions.

Frequency: ❍ 30 days ❍ Other (specify): _____

Dosage: ❍ 30 days ❍ Other (specify): _____

❑ New laboratory orders: _____

Signature: _____ Date:_____ Time:_____ ❍ AM ❍ PM
Attending Physician