



OKLAHOMA DEPARTMENT OF HUMAN SERVICES

Health Status and Monthly Medication Review



Service recipient	Review month	Year	Case number
DDSD case manager	Provider		Phone

Medication changes

List changes in non-prescription and prescription medication made during review.

Unusual or abnormal physical signs or symptoms

Any unusual physical sign, symptom, or concern for service recipient noted during review? Yes [ ] No [ ]
If yes, check any signs or symptoms exhibited or expressed by service recipient during review.

Appetite changes	<input type="checkbox"/>	Swallowing/coughing problems <ul style="list-style-type: none"> <li>Respiratory problems/shallow breathing – blue or gray lips/nails</li> <li>Fatigue while eating</li> <li>Food/liquid leaking from mouth/nose during meal</li> <li>Difficulty chewing for extended period of time</li> <li>Food residue left in mouth after swallowing</li> <li>Drool significantly</li> <li>Cough, choke, or gag at meals</li> </ul>	Urinary changes	<input type="checkbox"/>
Blood pressure changes	<input type="checkbox"/>		Visual disturbances	<input type="checkbox"/>
Body temperature	<input type="checkbox"/>		Weight changes	<input type="checkbox"/>
Change in bowel or bladder habits	<input type="checkbox"/>		Nausea/vomiting	<input type="checkbox"/>
Confusion/disorientation	<input type="checkbox"/>		Mood changes	<input type="checkbox"/>
Dizziness/unsteady	<input type="checkbox"/>		Pulse changes	<input type="checkbox"/>
Drowsiness	<input type="checkbox"/>		Rash/hives/itching	<input type="checkbox"/>
Fluid intake	<input type="checkbox"/>		Sleep problems	<input type="checkbox"/>
Headache	<input type="checkbox"/>		Slurred speech	<input type="checkbox"/>
Pain tolerance/verbalized	<input type="checkbox"/>		Other: _____	<input type="checkbox"/>

Signature \_\_\_\_\_ Date of review \_\_\_\_\_
Routing: Original – home record
Copy – DDSD case manager within two working days after completion