

Client File Overview:

(This Intake Package is to be completed by the Referral Worker. Please print all responses)

Date of Assessment: _____

Last Name: _____

First Name: _____ Known as: _____

Birthday: Year _____ Month _____ Day _____ Age _____ Gender: Male Female

Address: _____ City: _____ Province: _____

Postal Code: _____ Telephone #: _____ Cell #: _____
(Area Code) (Area Code)

Email: _____

S.I.N#: _____

Status Number: _____

Care Card # (Health #): _____

Aboriginal Ancestry Yes No What Nation? _____

Aboriginal Information (Band Name, Inuit, Métis, Aboriginal Community) _____

Living on Reserve Yes No

Marital Status: Married Common Law Divorced Separated Widowed Single

How long has this been the marital status? _____

Will the client's spouse be attending Treatment at KFDC as well? Yes No

Number of Children: _____ At home? _____ In Care? _____ Permanent care? _____ Length of Care? _____

Emergency Contact: _____ Telephone Number: _____

Emergency Contacts Relationship to Client: _____

Referring Agency: _____

Counsellor's Name: _____

Address: _____

Phone: _____ Cell: _____ Fax: _____

Email: _____

Client's Name: _____

Section 1 of 18 – Employment history

Source of Income: Job Social Assistance Disability Income

What is the client's occupation? _____

- Full Time Part Time Seasonal Unemployed Retired
 Temporary Self Employed Homemaker Student Training
 Permanent Not in Labour Force (*for any reason*)

Section 2 of 18 – Education

(Please check the highest level of education that has been completed)

- Elementary (kindergarten, Grades 1 – 12) Graduated High School (High School Diploma)
 Trade School (ex. Hairdressing, Carpentry, Welding) College (Post Secondary, Diploma)
 University (Bachelor, Masters) Adult Education

1. Does the client have any difficulty reading? Yes No
2. Does the client have any difficulty writing? Yes No
3. Will the client require any assistance with reading / writing? Yes No

Section 3 of 18 – Cultural / Spiritual

1. Is the client involved in any cultural / spiritual activities? Yes No

Please explain: _____

2. Does the client have any Healthy Elders in their life (outside of immediate family)? Yes No

Please explain: _____

3. Does the client see Culture as being part of their sobriety? Yes No

Please explain: _____

4. Is the client willing to participate in First Nation's cultural components such as: Sweat Lodge, daily Smudge, Pipe and other cultural ceremonies? Yes No

Please explain: _____

Section 4 of 18 – Family of Origin

1. Was substance misuse part of the client's family of origin? Yes No

Please describe issues: _____

Client's Name: _____

2. Did the client's parents (guardians) attend residential school? Yes No
 Can the client briefly share about their parent's residential school story? _____

3. Were the clients raised by their biological parents? Yes No
 If no, who raised them? _____

Section 5 of 18 – Pre Treatment Assessment

1. Is this client receiving counselling from you? Yes No

If "Yes", how many counselling sessions have been provided in the last three months? _____
 If "No", will you be seeing this client prior to treatment? _____

2. Is this client seeing another counsellor? Yes No

If "Yes", Please list the name and contact info for this counsellor: _____

N.B. Clients must have had a minimum of 6 one hour (or longer) pre-treatment counselling sessions with a Mental Health Worker (i.e. A&D or referral worker)

3. Will you be providing follow-up counselling with this client after their departure from KFDC?
 Yes No (Comments) _____

4. Does the client have a post-treatment appoint set? Yes No Date: _____

5. Has the client ever:	Attended	Willing to attend?
Alcoholics Anonymous	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Narcotics Anonymous	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Co-dependents Anonymous	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Other 12 Step Meetings	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Please check all areas of the client's life that have been affected by substance misuse?

- | | | | |
|--|--|------------------------------------|---|
| <input type="checkbox"/> Physical health | <input type="checkbox"/> Legal | <input type="checkbox"/> Housing | <input type="checkbox"/> Family / friends |
| <input type="checkbox"/> Employment | <input type="checkbox"/> Mental health | <input type="checkbox"/> Financial | <input type="checkbox"/> Spiritual / Cultural |

If you checked any of the above, please explain: _____

Client's Name: _____

7. Does the client express a strong desire (or willingness) to change their life? Yes No

8. Is the client willing to be involved in all types of intensive counselling activities? Yes No

9. What is the main reason that the client is applying for treatment at this time? _____

10. What goals does your client have for treatment?

a) _____

b) _____

c) _____

10. What other information could you provide to help us evaluate the client's needs (i.e. significant challenges, disability issues, life events, family patterns etc.) _____

Section 6 of 18 – Prior Treatment

<u>Name of Treatment Program</u>	<u>Dates Attended</u> (M / D / Y)	<u>Length of Sobriety</u>	<u>Completed Program</u>
a) _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) _____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 7 of 18 – Family Dynamic

1. How long has the client been married or in current relationship? _____

2. Has the couple been cohabitating? Yes No How long? _____ N/A

3. Is the client a Single parent? Yes No How long? _____ N/A

4. What does the couple (or single parent) identify as being the main reason for attending treatment?

5. Does the spouse have any substance misuse issues? Yes No N/A

6. Does the spouse receive any A&D counselling? Yes No N/A

Client's Name: _____

7. Do any of the children have substance misuse issues? Yes No

8. Have children ever been apprehended or placed in foster care? Yes No

If "Yes", what events led to the children's apprehension and how long have the children been in care?
Please explain: _____

9. Have the children been living with the parents? Yes No N/A

(If Yes How Long)? _____

(If no who have the children been living with)? _____

10. Will all of the client's children be coming to treatment with them? Yes No

11. If the children are currently in care but are being returned to the client to attend treatment, is the intention for the children to be permanently returned to the client at the end of our Family session?
 Yes No N/A

Please explain: _____

12. Does the family have any type of supervision order from a family protection agency? Yes No
(Please attach supervision order / documentation)

13. Is the client currently involved with any of the following: (please check all that apply)

- | | | |
|---|-------------|------------------|
| <input type="checkbox"/> MCFD | Name: _____ | Contact #: _____ |
| <input type="checkbox"/> Therapist | Name: _____ | Contact #: _____ |
| <input type="checkbox"/> Social Worker | Name: _____ | Contact #: _____ |
| <input type="checkbox"/> Mental Health Worker | Name: _____ | Contact #: _____ |
| <input type="checkbox"/> Legal Guardian(s) | Name: _____ | Contact #: _____ |
| <input type="checkbox"/> Other | Name: _____ | Contact #: _____ |

N.B. If there is involvement with any of the social resources noted in question #13: Please have all professionals that are involved with the client fill out and submit the "Referral workers / Counsellor's Assessment" outlined in Section 8 below.

Section 8 of 18 – Referral Worker / Counsellor Assessment

(This page to be completed by the A&D, Referral Worker)

1. What issues has the client worked on in his/her sessions and what is your perception of the client's readiness for treatment? _____

Client's Name: _____

2. What are the clients' presenting problems from the client's perspective? _____

3. Have you prepared this client for their involvement in the treatment program? _____

Section 9 of 18 – Trauma related history assessment

1. Has the client had a history of violent behaviour? Yes No

If yes, please explain: (offender / victim, when, circumstances, dates etc.) _____

2. Has the client experienced any type of trauma?

- Physical abuse Date: _____ if yes, please explain: _____
- Sexual abuse Date: _____ if yes, please explain: _____
- Emotional abuse Date: _____ if yes, please explain: _____
- Verbal abuse Date: _____ if yes, please explain: _____
- Economical abuse Date: _____ if yes, please explain: _____
- Spiritual abuse Date: _____ if yes, please explain: _____
- Domestic Violence Date: _____ if yes, please explain: _____
- Car Accident Date: _____ if yes, please explain: _____
- Fire Date: _____ if yes, please explain: _____
- Grief and loss Date: _____ if yes, please explain: _____
- Brain Trauma Date: _____ if yes, please explain: _____

3. Are any of the above a concern while at KFDC?

Yes No

Please explain: _____

Client's Name: _____

4. Did the client attend residential school?

Yes No

When? _____

How long? _____

Name and location of the residential school: _____

5. How does the client describe their residential school experience? _____

6. Is the Client currently involved in either of the following?

I. A. P.? Yes No

T. & R. Process? Yes No

Please explain:

7. Has the client experienced loss of a relative or close friend?

Yes No

8. If "yes", how was the person related to the client? _____

9. How did the loss occur?

Natural causes

Disease (i.e. cancer)

Suicide

Abandonment

Apprehension

Violent / Accidental Death

Arrest

Substance misuse related

10. What other losses have you experienced?

(E.g. Family pet, move, friend moving, etc)

11. Have you received counselling as a result of any of these experiences?

Yes No

If "yes", please explain: _____

12. Was the counselling beneficial to you?

Yes No

If "yes", please explain: _____

Client's Name: _____

13. Does the client have a history of?	Date(s)	Date(s)
Self-harm (e.g. cutting) <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Explain _____
Suicidal ideation <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Explain _____
Suicidal Planning <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Explain _____
Is suicide a concern? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Explain _____
Suicide in family? <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	Explain _____

Section 10 of 18 – Legal involvement

1. Does the client have any current legal orders in place for any reason? Yes No

2. Does the client have any Pending Charges / Court Dates? Yes No

3. Does the client have any current bail orders? Yes No

4. Does the client have any previous Convictions / Charges? Yes No

5. If you answered yes to any of the above. Please list all previous convictions / charges and dates (i.e. Spousal Assault, DUI, Theft, Breach, Failure to Appear, etc.): _____

6. Please identify the following people that are involved with the client:

<input type="checkbox"/> RCMP	Name: _____	Contact #: _____
<input type="checkbox"/> Probation Officer	Name: _____	Contact #: _____
<input type="checkbox"/> Court Worker	Name: _____	Contact #: _____

N.B. The client must not have any upcoming legal issues / court cases, during their stay at KFDC, ALL court dates must be dealt with prior to admission to Kackaamin Family Development Centre.

N.B. A copy of the Probation Order must be included with the application for treatment before it will be reviewed by the KFDC Intake Committee.

Section 11 of 18 – Substance Misuse History

Please put a **circle** around the primary drug(s) of choice.

N.B. in order to be admitted to KFDC's family program all clients must have a minimum of 3 weeks abstinence from any substances.

DRUG TYPE N.B. Please circle the drug(s) of choice	Name all substances used	Age of first use	How often used: Daily / Weekly / Monthly	Amount / Quantity used	Date of last use M/D/Y
Alcohol					
Cannabis (Pot, Hashish, Hash, Oil)					
Crack cocaine / Cocaine powder					
Stimulants (Crystal Meth / Ritalin)					
Painkillers					
Hallucinogen (Acid, Mushrooms, PCP)					
Sedatives (Sleeping Pills)					
Methadone					
Prescription drugs					
Non-Prescription (Cold Medication / Tylenol)					
Opiate (Morphine / Heroin / Oxy)					
Inhalants (Glue / Paint / Sprays / Solvents)					
Antidepressants					
Anti-Anxiety (Ativan / Valium / Librium / Zanax)					
Tobacco					
Other					

1. Has the client ever had a severe physical, mental or emotional reaction to their misuse? Yes No

Please Explain: _____

2. Has the client been hospitalized because of substance misuse? Yes No

If yes when and for how long? _____

Client's Name: _____

Section 12 of 18 – Alcohol Screening Test

#	The following questions are about your alcohol use in the past 12 months	Circle Your Response	
		YES	NO
1.	Do you feel that you are a normal drinker?	0	2
2.	Do friends or relatives think you are a normal drinker?	0	2
3.	Have you attended a meeting of Alcoholics Anonymous (AA)?	5	0
4.	Have any of your friendships or relationships ever been ended because of your drinking?	2	0
5.	Have you gotten into trouble at work because of your drinking?	2	0
6.	Have you neglected your obligations, your family or your work for two or more days in a row because you were drinking?	2	0
7.	Have you ever had delirium tremens (DT's) or severe shaking?	2	0
8.	Have you gone to anyone for help about your drinking?	5	0
9.	Have you been in a hospital because of drinking?	5	0
10.	Have you received a 24-hour roadside suspension or have you been charged with impaired driving?	2	0
Total Score			

N.B. Total scores may range from 0 to 29. Scores of 10 or greater are considered to reflect serious problems with alcohol misuse.

To get a Total: please combine the “No” scores with the “Yes” scores.

Alcohol Misuse Screening Test Score	Problem Severity
0	No Problem
1 - 5	Low level of problems related to alcohol misuse
6 - 10	Moderate level of problems related to alcohol misuse
11 - 15	Substantial level of problems related to alcohol misuse
16 - 29	Severe level of problems related to alcohol misuse

Section 13 of 18 – Drug Screening Test

#	The following questions are about your Drug use in the past 12 months	Circle Your Response	
		YES	NO
1.	Have you used drugs other than those required for medical reasons?	2	0
2.	Have you ever abused prescription drugs?	2	0
3.	Do you ever use more than one drug at a time?	2	0
4.	Can you get through the week without using drugs?	0	1
5.	Are you able to stop using drugs when you want to?	0	1
6.	Have you had “blackouts” or “flashbacks” as a result of drug use?	1	0
7.	Do you ever feel bad or guilty about your drug use?	1	0
8.	Does your spouse (or parents) ever complain about your involvement with drugs?	1	0
9.	Has drug abuse ever created problems between you and your spouse or your parents?	1	0
10.	Have any of your friendships or relationships ever been ended because of your drug use?	1	0
11.	Have you neglected your family because of your use of drugs?	3	0
12.	Have you been in trouble at work because of drug abuse?	1	0
13.	Have you lost a job because of drug use?	1	0
14.	Have you gotten into fights when under the influence of drugs?	1	0
15.	Have you engaged in illegal activities in order to obtain drugs?	1	0
16.	Have you been arrested for possession of illegal drugs?	3	0
17.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	1	0
18.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc)?	1	0
19.	Have you gone to anyone for help for drug problem?	3	0

Client's Name: _____

20.	Have you been involved in a treatment program specifically related to drug use?	YES 1	NO 0
	Total Score		

N.B. Total scores may range from 0 to 29. Scores of 10 or greater are considered to reflect serious problems with drug misuse.

To get a Total: please combine the “No” scores with the “Yes” scores.

Drug Misuse Screening Test Score	Problem Severity
0	No Problem
1 - 5	Low level of problems related to drug misuse
6 - 10	Moderate level of problems related to drug misuse
11 - 15	Substantial level of problems related to drug misuse
16 - 29	Severe level of problems related to drug misuse

Section 14 of 18 – Consent to attend treatment

I (PRINT Client's Name) _____, have reviewed each statement below with my A&D / Referral Worker and have initialled in the space provided as confirmation of my understanding.

1. ____ I understand that an incomplete application and lack of supporting documentation will cause delays in the intake process and affect my intake date.
2. ____ I give consent to the Intake Coordinator to contact my referring agency, Probation Officers, Medical Practitioner's, etc. to obtain clarification on information included in this application.
3. ____ I understand that the Intake Coordinator will notify my referral worker by letter to confirm my acceptance to treatment.
4. ____ If I am on Income Assistance, I give consent for the Intake Coordinator to forward confirmation of my intake and discharge dates to my Employment and Assistance Worker.
5. ____ I understand if I have legal issues, a copy all legal orders must be submitted with the application for treatment and all pending court dates must be dealt with prior to admission to Kackaamin Family Development Centre.
6. ____ All outside business that may interfere with my participation in the treatment program has been attended to.
7. ____ While in treatment, I understand that if I need medical attention I will be taken to the appropriate medical personnel.
8. ____ I understand that if I am discharged early or voluntarily leave treatment that I am responsible for return travel. I will be arriving at treatment with my return travel arrangements in place.
9. ____ I understand that if I do not have 3 weeks abstinence from all substances that it may result in my immediate discharge from the program.

(Client's Signature)

(Date)

(Referral Worker's Signature)

(Date)

Client's Name: _____

Section 15 of 18 – Consent to release Confidential Information

I (client), _____ hereby request and permit KFDC staff to discuss any and all confidential information and assessments with my referral worker listed below.

Signature of Client: _____ Date: _____

Referral Worker's Name: _____

Organization / Agency's Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Contact #: _____ Fax #: _____

Email Address: _____

Alternate Contact Person within your organization: _____

(The alternate contact person is for the confirmation and admission process only. The alternate contact will not be included in the release of confidential information prior to, during, or after treatment. The client may change the name of the person that receives the Discharge Summary at any time. It is up to the client to inform their referral worker of that change. N.B. This form is only applicable for one year after the date it is signed.)

Section 16 of 18 – Consent to release Client Medical Information

I (client), _____, hereby request and permit my physician to release any medical facts and assessments to Kackaamin Family Development Centre and the referring agency listed above.

Signature of Client: _____ Date: _____

N.B. for the attending Physician:

KFDC requires the above client to be medically assessed as a potential participant in our six week residential substance misuse treatment program. The KFDC program is designed to help people acknowledge that substance misuse has interfered with their lives. Please assess if they are physically and mentally ready to participate in a treatment program that offers counselling and educational workshops. All clients are required to have complete physical examination prior to admission. They should not require any acute medical care at the time of admission. All communicable diseases should be in remission and properly medicated.

Client's Name: _____

Section 17 of 18 – Pre admission Medical Information

(To Be Completed by the Physician / RN / CHN)

Patient's Name: _____ Date of Birth: _____

Care Card Number: _____ Status Number: _____

Physical Exam – medical information

1. Known Allergies: Yes No

If "yes", what is the Patient allergic to? _____

N.B. the patient must bring their own epipen if they are apitoxin allergic. Please prescribe one if needed.

2. Please check all issues that apply.

- | | | | | | |
|---|-----------------------------------|--|------------------------------------|-----------------------------------|-------------------------------------|
| <input type="checkbox"/> E.E.N.T. | <input type="checkbox"/> Liver | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> F.A.S.D. | <input type="checkbox"/> S.O.B | <input type="checkbox"/> D.T.'s |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pregnant | <input type="checkbox"/> C.H.F. | <input type="checkbox"/> Arthritis | <input type="checkbox"/> G.U. | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> G.I. | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Dyspepsia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Prostatism |
| <input type="checkbox"/> Freq U.T.I. <input type="checkbox"/> Neurological disorder | | | | | |
| <input type="checkbox"/> Epilepsy <input type="checkbox"/> Date of last seizure _____ | | | | | |
| <input type="checkbox"/> HIV / AIDS | | | | | |
| <input type="checkbox"/> S.T.I. Type _____ | | | | | |

Hepatitis *(please circle any that apply)* A B C

Sensory Impairment *(please circle any that apply)* vision hearing olfactory

Does the patient have any other type of special need (i.e. learning disability, difficulties with reading, writing) Yes No

Please describe: _____

Tuberculosis ~ TB *(please circle any that apply)* Active Dormant
(The patient must have had a T.B. Test in the last 12 months) Date _____

N.B. If the TB skin test is positive and the results measure larger than 10mm, a subsequent TB chest X-ray must be performed.

3. Does the patient have a heart condition? *(Please name the condition)* _____

What is the patient's Blood Pressure? _____

4. Does the patient have an infestation of any kind (i.e. lice, scabies)? _____

Client's Name: _____

5. Diabetes: Yes No
 Does the patient manage blood glucose levels with: Diet Pills Insulin Injection?
 What are the target blood glucose levels? _____

6. Has the patient ever been diagnosed with a Mental Health Problem? Yes No
 If yes when: _____ (date) Specify the diagnosis _____
 Name of Psychiatrist/Psychologist: _____ Phone: _____

7. Does the patient have allergies to any medications? _____

8. Are you aware of current or recent medical problems which may require follow-up while the patient is in treatment at KFDC? Yes No

9. Does the patient have a dual diagnosis or co-morbidity? Yes No

If "Yes" please list the illness, date of diagnosis, medication prescribed and any information that you deem pertinent.

N.B. Pregnant Clients may be admitted to KFDC if they are NO more than 7 months along.

Section 18 of 18 - PRE-Admission Best Possible Medication History (BPMH)

The BPMH is compiled using a number of different sources and includes information about prescription medications, non-prescription medications, vitamins, and supplements, along with detailed documentation of drug name, dose, frequency, and route of administration. Medication reconciliation is a shared responsibility which must involve the client or family. Liaison with the primary care provider and community pharmacist may be required.

Medication Name	Current Dose	Taking since	Client Initials	Date Finished

Client's Name: _____

Name: _____
(Physician / RN / CHN's Name)

Address: _____

City: _____

Postal Code: _____

Telephone: _____

Fax: _____

OFFICE STAMP

(Physician / RN / CHN's Signature)

(Date)

Instructions for all Agencies and Medical Professionals:

Please mail or fax completed forms to the attention of:

Holly Millar

Intake Coordinator

Kackaamin Family Development Centre

7830 Beaver Creek Road

Port Alberni, BC V9Y 8N3

Email: intake@kackaamin.org

Business #: (250) 723-7789

Fax #: (250) 723-5926

Client's Name: _____

QUICK REFERENCE TO PSYCHOTROPIC MEDICATIONS®

DEVELOPED BY JOHN PRESTON, PSY.D., ABPP

To the best of our knowledge recommended doses and side effects listed below are accurate. However, this is meant as a general reference only, and should not serve as a guideline for prescribing of medications. Please check the manufacturer's product information sheet or the P.D.R. for any changes in dosage schedule or contraindications. (Brand names are registered trademarks.)

ANTIDEPRESSANTS

NAMES		Usual Daily Dosage Range	Sedation	ACH ¹	Selective Action On Neurotransmitters ²		
Generic	Brand				NE	5-HT	DA
imipramine	Tofranil	150-300 mg	mid	mid	++	+++	0
desipramine	Norpramin	150-300 mg	low	low	+++++	0	0
amitriptyline	Elavil	150-300 mg	high	high	++	++++	0
nortriptyline	Aventyl, Pamelor	75-125 mg	mid	mid	+++	++	0
protriptyline	Vivactil	15-40 mg	mid	mid	++++	+	0
trimipramine	Surmontil ³	100-300 mg	high	mid	++	++	0
doxepin	Sinequan, Adapin ³	150-300 mg	high	mid	++	+++	0
clomipramine	Anafranil	150-250 mg	high	high	0	+++++	0
maprotiline	Ludiomil	150-225 mg	high	mid	+++++	0	0
amoxapine	Asendin	150-400 mg	mid	low	+++	++	0
trazodone	Desyrel	150-400 mg	mid	none	0	++++	0
nefazodone	Generic Only	100-300 mg	mid	none	0	+++	0
fluoxetine	Prozac ⁴ , Sarafem	20-80 mg	low	none	0	+++++	0
bupropion-X.L.	Wellbutrin-X.L. ⁴	150-400 mg	low	none	++	0	++
sertraline	Zoloft	50-200 mg	low	none	0	+++++	+
paroxetine	Paxil	20-50 mg	low	low	+	+++++	0
venlafaxine-X.R.	Effexor-X.R. ⁴	75-350 mg	low	none	++	+++	+
desvenlafaxine	Pristiq	50-400 mg	low	none	++	+++	+
fluvoxamine	Luvox	50-300 mg	low	low	0	+++++	0
mirtazapine	Remeron	15-45 mg	mid	mid	+++	+++	0
citalopram	Celexa	10-60 mg	low	none	0	+++++	0
escitalopram	Lexapro	5-20 mg	low	none	0	+++++	0
duloxetine	Cymbalta	20-80 mg	low	none	++++	++++	0
vilazodone	Viibryd	10-40 mg	low	low	0	+++++	0
atomoxetine	Strattera	60-120 mg	low	low	+++++	0	0
MAO INHIBITORS							
phenelzine	Nardil	30-90 mg	low	none	+++	+++	+++
tranylcypromine	Parnate	20-60 mg	low	none	+++	+++	+++
selegiline	Emsam (patch)	6-12 mg	low	none	+++	+++	+++

¹ACH: Anticholinergic Side Effects

²NE: Norepinephrine, 5-HT: Serotonin, DA: Dopamine (0 = no effect, + = minimal effect, +++ = moderate effect, ++++ = high effect)

³Uncertain, but likely effects

⁴Available in standard formulation and time release (XR, XL or CR). Prozac available in 90mg time released/weekly formulation

BIPOLAR DISORDER MEDICATIONS

NAMES				NAMES			
Generic	Brand	Daily Dosage Range	Serum ¹ Level	Generic	Brand	Daily Dosage Range	Serum ¹ Level
lithium carbonate	Eskalith, Lithonate	600-2400	0.6-1.5	divalproex	Depakote	750-1500	50-100
olanzapine/ fluoxetine	Symbyax	6/25-12/50mg ⁴	2	lamotrigine	Lamictal	50-500	(2)
carbamazepine	Tegretol, Equetro	600-1600	4-10+	topiramate	Topamax	50-300	(3)
oxcarbazepine	Trileptal	1200-2400	(2)	tiagabine	Gabitril	4-12	(3)

¹Lithium levels are expressed in mEq/l, carbamazepine and valproic acid levels express in mcg/ml.

²Serum monitoring may not necessary ³Not yet established ⁴Available in: 6/25, 6/50, 12/25, and 12/50mg formulations

ANTI-OBSESSIVE

NAMES		
Generic	Brand	Dose Range ¹
clomipramine	Anafranil	150-300 mg
fluoxetine	Prozac ¹	20-80 mg
sertraline	Zoloft ¹	50-200 mg
paroxetine	Paxil ¹	20-60 mg
fluvoxamine	Luvox ¹	50-300 mg
citalopram	Celexa ¹	10-60 mg
escitalopram	Lexapro ¹	5-30 mg

¹often higher doses are required to control obsessive-compulsive symptoms than the doses generally used to treat depression.

PSYCHO-STIMULANTS

NAMES		
Generic	Brand	Daily Dosage ¹
methylphenidate	Ritalin	5-50 mg
methylphenidate	Concerta ²	18-54 mg
methylphenidate	Metadate	5-40 mg
methylphenidate	Methylin	10-60 mg
methylphenidate	Daytrana (patch)	15-30 mg
dexamethylphenidate	Focalin	5-40 mg
dextroamphetamine	Dexedrine	5-40 mg
lisdexamphetamine	Vyvanse	30-70 mg
d- and l-amphetamine	Adderall	5-40 mg
modafinil	Provigil, Sparlon	100-400 mg

¹Note: Adult Doses. ²Sustained release

ANTIPSYCHOTICS

NAMES		Brand	Dosage Range ¹	Sedation	Ortho ²	EPS ³	ACH Effects ⁴	Equivalence ⁵
Generic								
LOW POTENCY								
chlorpromazine		Thorazine	50-800 mg	high	high	++	++++	100 mg
thioridazine		Mellaril	150-800 mg	high	high	+	+++++	100 mg
clozapine		Clozaril	300-900 mg	high	high	0	+++++	50 mg
mesoridazine		Serentil	50-500 mg	high	mid	+	+++++	50 mg
quetiapine		Seroquel	150-600 mg	mid	mid	+/-0	+	50 mg
HIGH POTENCY								
molindone		Moban	20-225 mg	low	mid	+++	+++	10 mg
perphenazine		Trilafon	8-60 mg	mid	mid	++++	++	10 mg
loxapine		Loxitane	50-250 mg	low	mid	+++	++	10 mg
trifluoperazine		Stelazine	2-40 mg	low	mid	++++	++	5 mg
fluphenazine		Prolixin ⁵	3-45 mg	low	mid	+++++	++	2 mg
thiothixene		Navane	10-60 mg	low	mid	++++	++	5 mg
haloperidol		Haldol ⁵	2-40 mg	low	low	+++++	+	2 mg
pimozide		Orap	1-10 mg	low	low	+++++	+	1-2 mg
risperidone		Risperdal	4-16 mg	low	mid	+	+	1-2 mg
paliperidone		Invega	3-12 mg	low	mid	+	+	1-2 mg
olanzapine		Zyprexa	5-20 mg	mid	low	+/-0	+	1-2 mg
ziprasidone		Geodon	60-160 mg	low	mid	+/-0	++	10 mg
iloperidone		Fanapt	12-24 mg	mid	mid	+	++	1-2 mg
asenapine		Saphris	10-20 mg	low	low	+	+	1-2 mg
lurasidone		Latuda	40-80 mg	mid	mid	+	+	10 mg
aripiprazole		Abilify	15-30mg	low	low	+	+	2 mg

¹Usual daily oral dosage

²Orthostatic Hypotension. Dizziness and falls

³Acute: Parkinson's, dystonias, akathisia. Does not reflect risk for tardive dyskinesia. All neuroleptics may cause tardive dyskinesia, except clozapine.

⁴Anticholinergic Side Effects.

⁵Dose required to achieve efficacy of 100 mg chlorpromazine.

⁶Available in time-release IM format.

ANTI-ANXIETY

NAMES		Brand	Single Dose Dosage Range	Equivalence ¹
Generic				
BENZODIAZEPINES				
diazepam		Valium	2-10 mg	5 mg
chlordiazepoxide		Librium	10-50 mg	25 mg
prazepam		Centrax	5-30 mg	10 mg
clorazepate		Tranxene	3.75-15 mg	10 mg
clonazepam		Klonopin	0.5-2.0 mg	0.25 mg
lorazepam		Ativan	0.5-2.0 mg	1 mg
alprazolam		Xanax, XR	0.25-2.0 mg	0.5 mg
oxazepam		Serax	10-30 mg	15 mg
OTHER ANTIANXIETY AGENTS				
bupirone		BuSpar	5-20 mg	
gabapentin		Neurontin	200-600 mg	
hydroxyzine		Atarax, Vistaril	10-50 mg	
propranolol		Inderal	10-80 mg	
atenolol		Tenormin	25-100 mg	
guanfacine		Tenex	0.5-3 mg	
clonidine		Catapres	0.1-0.3 mg	
prazosin		Minipress	5-20 mg	

¹Doses required to achieve efficacy of 5 mg of diazepam

HYPNOTICS

NAMES		Brand	Single Dose Dosage Range
Generic			
flurazepam		Dalmane	15-30 mg
temazepam		Restoril	15-30 mg
triazolam		Halcion	0.25-0.5 mg
estazolam		ProSom	1.0-2.0 mg
quazepam		Doral	7.5-15 mg
zolpidem		Ambien	5-10 mg
zaleplon		Sonata	5-10 mg
eszopiclone		Lunesta	1-3 mg
ramelteon		Rozerem	4-16 mg
diphenhydramine		Benadryl	25-100 mg

OVER THE COUNTER

Name	Daily Dose
St. John's Wort ^{1,2}	600-1800 mg
SAM-e ³	400-1600 mg
Omega-3 ⁴ -EPA	1-2 g

¹Treats depression and anxiety

²May cause significant drug-drug interactions

³Treats depression

⁴Treats depression and bipolar disorder

REFERENCES and RECOMMENDED BOOKS

Quick Reference • Free Downloads

Website: www.PsyD-fx.com

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Clinical Psychopharmacology Made Ridiculously Simple 6th Edition
(2011) Preston and Johnson

Consumer's Guide to Psychiatric Drugs
(2009) Preston, O'Neal, Talaga

Child and Adolescent Psychopharmacology Made Simple

(2010) Preston, O'Neal, Talaga