

TREATMENT UTILIZATION FORM

Colorado

Pittsburgh

ID

DATE / /

Interviewer's Initials

Respondent: Mother Father Other, specify:

This interview concerns:

1. What medications and dosages has your (his/ her) doctor prescribed over the last 3 months? **Fill in circle if none**

Medication	Dosage		# of days	Adherence (1-3)*
<input type="text"/>	<input type="text"/>	<input type="radio"/> mg	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> pills/day	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> mg	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> pills/day	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> mg	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> pills/day	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> mg	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> pills/day	<input type="text"/>	<input type="text"/>

* When filling out the Adherence column, ask the following: "Many people miss their pills from time to time. How has it been for you (him/ her)?"

- 1= You take your medications as prescribed very consistently, with few or no missed dosages; all evidence suggests compliance.
- 2= You take medications intermittently (i.e., whole days missed, [for example, a day per week], take certain medications inconsistently but not others, missed one or more weekends, often miss evening dosages, take medications at lower dosages than prescribed).
- 3= You have stopped taking this (or all) medication despite your doctor's recommendation.

2. Have you (has _____) stopped taking medication? Yes No
If yes, why?

3. Have you (has _____) received any psychotherapy/ counseling? Yes No
If so, what type and how often?

4. Has your spouse received any other counseling? Yes No
If so, what type and how often?

5. Have you (has _____) been hospitalized, or partially hospitalized in the last three months? Yes No
If so, where, how long and why?

Visit Month

- Initial
- 3 month
- 6 month
- 9 month
- 12 month
- 18 month
- 24 month

Draft

