Northeast Ohio MEDICAL UNIVERSITY

Best Practices in Schizophrenia Treatment (BeST) Center

*Promoting Innovation. Restoring Lives.*

SZ consult case report form

**Forms may be emailed or faxed**
**email: szconsult@neomed.edu**
**fax: 330-325-5970**

**Do Not Include Personal Identifiers**

**What is the question… what would you like help with?**

**Clinician name**

**Clinician contact information**
**Email**
**Phone**

**Age and gender of patient**

**Drug, alcohol, tobacco use**

| Substance | Uses (Y/N) | How often? |
|---|---|---|
| Cigarettes | | |
| Other nicotine products | | |
| Marijuana | | |
| Alcohol | | |
| Other (specify) | | |

**Current medications (including non-psychiatric meds)**

**Please list prior antipsychotic medications (if any), including their dose (if know), duration of treatment (if known), and reason for discontinuation (if applicable)**

| Medication | Dose | Duration | Reason for discontinuation |
|---|---|---|---|

**What other medical illnesses are present?**

**Any recent laboratory studies?**
**If so, please:**

- **list which tests were ordered,**
- **list abnormal results (if any).**

**If tests include serum drug concentrations, please list those values**

**Describe the patient's living situation and social supports**