

# Telephone Follow-Up Encounter Form

Date: \_\_\_\_\_

1. Has your child been taking the medication?  **Yes**  **No** Current Medication/Dose: \_\_\_\_\_  
If **NO**, list reason: \_\_\_\_\_  
When will meds be initiated? \_\_\_\_\_ Date of rescheduled 14-day phone contact: \_\_\_\_\_

2. Over the past 2 weeks, how would you describe your child's general level of hyperactivity, impulsivity, and inattention (at home and at school) compared with before starting medication?

**At home:**

Hyperactivity:  Worse  No change  Slightly Improved  Much Improved  N/A  
Impulsivity:  Worse  No change  Slightly Improved  Much Improved  N/A  
Inattention:  Worse  No change  Slightly Improved  Much Improved  N/A

**At school:**

Hyperactivity:  Worse  No change  Slightly Improved  Much Improved  N/A  
Impulsivity:  Worse  No change  Slightly Improved  Much Improved  N/A  
Inattention:  Worse  No change  Slightly Improved  Much Improved  N/A

**Overall Progress:**  Worse  No change  Slightly Improved  Much Improved

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3. Over the past 2 weeks, has there been a difference between your child's behavior in the AM versus the PM (e.g., medicine wearing off too soon, problems with rebound)?  **Yes**  **No**

4. Have you observed any possible side effects from the medication (i.e., trouble sleeping, trouble eating, aches, or any other behaviors) that were not present or have gotten worse since your child began taking the medication?  **Yes**  **No** If yes, list side effect(s): \_\_\_\_\_  
\_\_\_\_\_

**PLAN:**

A. Continue current dose

B. Change dose: Increase to \_\_\_\_\_ Decrease to \_\_\_\_\_

C. Change medication: \_\_\_\_\_