

**Partners in Care**

**YOUR PERSONAL PLAN:  
Medications**

Patient Name:

Study ID#:

CONTACT/APPOINTMENT INFORMATION

Primary Care Clinician:

Tel. N2: \_\_\_\_\_

Depression Nurse Specialist:

Tel. N2: (     ) \_\_\_\_\_

>Next appointment:

Date / /

Time:

(circle one)  
am /pm

**YOUR MEDICATION SCHEDULE**

Name of medication:

From:

To:

1<sup>st</sup> Take tablet(s) of mg every morning/evening for days / /

® 2<sup>nd</sup> Take tablet(s) of mg every morning/evening for days / /

3<sup>rd</sup> Take tablet(s) of mg every morning/evening for days / /

TN! 4<sup>th</sup> Take tablet(s) of mg every morning/evening for days / /

**NOTE:** *The medication is started at a low dose to give your body time to adapt. if you are having side effects, you can stay at a lower dose for a little longer and then increase the amount. **Remember: It may take a few weeks before you experience the medication's full effect, so don't get discouraged.***

**\* IMPORTANT!!!**

**DON'T STOP THE MEDICATION BEFORE CALLING YOUR DOCTOR**

**SYMPTOMS TO MONITOR**

**I** if you are having this symptom:

Anxiety attacks

Decreased or increased appetite

Feeling depressed or sad

Aches and pains

Feeling slowed down or sped up/jittery

Loss of interest or pleasure

Problems with sleep

*U Feelings of worthlessness or guilt*

Nervousness or tension

Trouble thinking, concentrating, or deciding

*Wishing you were dead or thinking about suicide*

Fatigue or loss of energy

Others: \_\_\_\_\_

**YOUR QUESTIONS/CONCERNS**

Bring this form to your next visit. Record any questions, problems, or concerns you may have about your current treatment here:

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_