APMRT

Alabama Psychiatric Medication Review Team

A Collaboration between
Auburn University Department of Psychology & AL-DHR

Neuroleptic Drug Side Effects Rating Scale

Name of Child: _____ Date: _____

Person Completing This Form: _____ Duration of Contact with Client: _____

Instructions

This questionnaire is about how the child has been recently. It is being used to determine if the child is suffering from excessive side effects from his/her antipsychotic medication.

Please place a check in the column which best indicates the degree to which the child has experienced the following side effects. Check the last box if the side effect has distressed the child.

Over the past week:	Not observed	Never	Once	A few times	Everyday	Check this box if distressing
Felt sleepy during the day						
Felt drugged or like a zombie						
Felt dizzy when stood up and/or fainted						
Felt heart beating irregularly or unusually fast						
Muscles have been tense or jerky						
Hands or arms have been shaky						
Legs have felt restless and/or couldn't sit still						
Has been drooling						
Movements or walking have been slower than usual						
Has had uncontrollable movements of face or body						
Vision has been blurry						
Mouth has been dry						
Has had difficulty passing urine						
Has felt like he/she was going to be sick or has vomited						
Has wet the bed						
Has been very thirsty and/or passing urine frequently						
Areas around nipples have been sore and swollen						
Fluid coming from nipples						

Check yes or no for the following questions about the last three months	Not observed	No	Yes	Check this box if distressing
Women only: a change in periods				
Men and women: has been gaining weight				

Source: Glasgow Antipsychotic Side-effect Scale GASS): Waddell L and Taylor M. J Psychopharmacol 2008; 22(3): 238-243.