Communities Connected for Kids

PLACEMENT CHANGE FORM FOR CHILDREN ON MEDICATION

Note: Pill counts are to be completed **IN PERSON** *when picking the child up from his/her current placement and then again at the time of placing the child.*

Case Name: _____ **Date of Placement Change:** _____
Name of Child: _____ **DOB:** _____
PCP Name & Phone: _____ **Psychiatrist Name & Phone:** _____
Pharmacy Name & Phone: _____
Person Transporting Child: _____ **DCM:** _____

As of this date, the next *Psychotropic Medication* appointment for the child is _____ at _____ am/pm.

The DCM has reviewed possible side effects of the medications and the reason the child is on the medication with me as indicated in the most recent med report (5339).

Inventory							
Medication Name & Dosage	**RX #**	**Diagnosis or purpose**	**Prescribing Physician**	**Time & frequency of administration**	**Side effects**	**Pill Count Leaving Placement**	**Pill Count upon Arrival to New Placement**

_____ _____ _____ _____

Signature Caregiver Child is Moving from | Date | Signature Caregiver Child is Moving to | Date

_____ _____ _____ _____

Signature DCM/ Transporter | Date | Signature DCM/ Transporter | Date

Caregiver: I verify that the DCM spoke with me about the information on this form. I verify that I have received these medications, their instructions and that I clearly understand and read the dosage information on the medication bottle.

Transporter: I have verified the Name of the Child on the medication, the quantity of each medication and entered the quantity in the form above.