Communities Connected for Kids

30-Day Home Visit Psychotropic Medication Review

Child Name:_____ DOB:_____ Case Name:_____

Date of Home Visit:_____ Placement Type:_____

Treating Physician:_____ Name of Placement/Caregiver:_____

Date of Last med Mgmt Appt:_____ Date of Next Med Mgmt Appt:_____

Psychotropic Medication	Dosage	How many times a day?	Diagnosis and symptoms treated	Date Filled	Quantity Filled	# of Refills	Pill Count	Stopped? Y/N	If Yes, Reason Stopped

Are parental rights still intact to consent to medication? Yes ☐ No ☐
If no, is there a court order authorizing medication? Yes ☐ No ☐
If yes, did the parent(s) receive a copy of the Physician's Report? Yes ☐ No ☐
If yes, has a parent consented to the meds by signing the Physician's Report? Yes ☐ No ☐
If yes, did the parent(s) receive a monthly progress update as to the child's medication? Yes ☐ No ☐
Is the child taking medication as prescribed? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Has the med log been reviewed and medication count been completed with administration showing as accurate? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Has the caregiver reported any side effects from the medication(s)? Yes ☐ No ☐
If Yes, what side effects and please explain the reasons and follow-up action to be taken:

_____

Has the caregiver noticed that the medication(S) have had a positive impact on the child's functioning/behavior? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Does the child feel that the medication is helpful? Yes ☐ No ☐
If no, please explain reasons and follow-up action to be taken:

_____

Does the child or caregiver have any questions or concerns about the medication? Yes ☐ No ☐
If yes, please list them as well as any follow-up action to be taken:

_____

_____ _____ _____ _____
Dependency Case Manager Signature Date Caregiver Signature Date