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 _____

☐ **The DCM has reviewed possible side effects of the medications and the reason the child is on the medication with me as indicated on 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.