Appendix 2: Medication Documentation

Psychotropic Medication Checklist for Youth in Care

Name of Child		Caseworker	
Date of Birth		Date of Custody	
Height		Weight	

Medication	Dose	Route	Times

Diagnoses:

Provider:		Clinician	
Phone #:		Email:	

Diagnostic Assessment Obtained?	YES	NO	Not Available
Individualized Service Plan Obtained?	YES	NO	Not Available
Medication History Obtained?	YES	NO	Not Available
Most Recent Provider Progress Note Obtained?	YES	NO	Not Available

Completed by: _____ Date: _____