October 2019

Region 02 Placement Change

Purpose: The purpose of this form is to transfer information from one caregiver to another in order to enhance continuity of care for the child.

Instructions: This form is to be completed by the current caregiver prior to the discharge of a child. 2INgage will ensure both the new caregiver and Case Manager are provided a copy at the time of placement.

Social

What are the child's interests, skills, and Strengths?
Describe the child's current social interaction (include friends, frequency of contact, activities and organizations, and church involvement).

If age appropriate, describe the child's social interaction with dating/relationships.
Does the child have access to a telephone or computer? If so how often is the child allowed to use the telephone or computer?
Are there any additional social needs?

Mental and Behavioral Health

Does the child have any developmental delays? Yes ☐ No ☐ If yes, explain:
Does the child have any mental or behavioral health diagnoses: Yes ☐ No ☐ If yes, explain:
Does the child have any behavior that could pose a threat to themselves or others: Yes ☐ No ☐ If yes, explain:
Are there any special instructions regarding assisting the child to manage their behaviors?

Does the child have a substance abuse disorder: Yes ☐ No ☐
If yes, list substances the youth is presently using or has used in the past:

If yes, explain what services are being provided:

Special issues that the receiving caregiver needs to be aware of (include information about situations that trigger significant emotional responses and successful intervention strategies)

Are there any additional Mental/Behavioral health needs?

Psychiatric Services

Does the child see a Psychiatrist? Yes ☐ No ☐
If Yes:
Name of Psychiatrist:
Address:
Phone No:
Date Last seen:

Is a follow-up appointment needed: Yes ☐ No ☐
If yes, date scheduled:
Time:
Location:

What needs have been identified?

Therapy

Does the child see a therapist? Yes ☐ No ☐
If Yes:
Therapist Name:
Address:
Phone No:
Date Last Seen:
Next Appt:
Comments:

Medical

Name of primary physician:
Address:
Date last seen by primary physician:
Future Appointments:

Does the child have any medical conditions? (acute or chronic) Yes ☐ No ☐
If Yes, list:

Does the child have any allergies? Yes ☐ No ☐
If yes, list:

Does the child receive any in-home medical services? Yes ☐ No ☐
If yes, what services are provided?

Provider Name:
Address:
Phone No:
Does the child have special medical equipment or supplies? Yes ☐ No ☐
If yes, list items:

Does the child see any specialists? Yes ☐ No ☐ If yes, provider name and contract information:
Attach copy of immunizations. Are they up to date? Yes ☐ No ☐
Does the child have any specific dietary needs? Yes ☐ No ☐ If yes, list special needs:
Are there any additional medical needs? Yes ☐ No ☐ If yes, list:

Current Medications

Medication	Prescriber	Dosage	Frequency	Special Instructions	Last filled	Reason for Medication

Medication	Prescriber	Dosage	Frequency	Special Instructions	Last filled	Reason for Medication

Over the Counter Medication or Supplements:

Medication/Supplement Name	Dosage	Frequency	Special Instructions	Date picked up	Reason for Medication/ Supplement

Dental

Name of Dental Provider:
Address:

Phone Number: Services Provided:
Date Last Seen:
Is a follow up appointment scheduled? Yes ☐ No ☐
If yes, date of follow-up:

Caregiver/Provider must ensure the following items are provided.

These documents have been provided previously or are attached to discharge notice.

- ☐ **Assessments and/or evaluations that have been completed during the time of placement**
- ☐ **Copy of most recent Single Case Plan**
- ☐ **Medicaid Card**
- ☐ **Birth Certificate (if available) Social**
- ☐ **Security Card (if available)**
- ☐ **Immunization Record**
- ☐ **Updated Clothing and Personal Items Inventory (to be completed and provided at time of discharge)**
- ☐ **Educational Portfolio (to be provided at the time of discharge)**
- ☐ **Life Book (to be provided at the time of discharge)**

Signatures

Current Caregiver who completed information:	**Date Signed:**
Current CPA or Residential Provider:	**Date Signed:**
Reviewed by receiving Caregiver:	**Date Reviewed:**
Reviewed by receiving CPA/Residential Provider:	**Date Reviewed**