St. Clair County Community Mental Health

Medication Transfer

This form is to be completed when medications are required to be sent to a St. Clair County Community Mental Health (SCCCMH) Program and/or when Individuals are moved from one Group Home/Adult Foster Care (AFC) to another.

Instructions: Fill out each portion in its entirety. Send over all medications in their original pharmacy container with instructions for use printed on the label.

Individual: _____ OASIS Case #: _____ Date of Birth: _____

Sending Party

_____ **Title:** ☐ Group Home Supervisor ☐ Parent ☐ Designee

Facility/Program Name *(if applicable)*

Receiving Party

_____ **Title:** ☐ Program Supervisor ☐ Designee

Facility/Program Name

Name of Medication	Strength	Quantity Sent	Sending Party Initials	Quantity Received	Receiving Party Initials

* If more than 10 medications are being transferred, please fill out an additional form.

By signing below, you are agreeing that all medications and counts listed above are accurate.

_____ _____ _____

Sending Party Signature/Credentials | Print Name | Date

_____ _____ _____

Receiving Party Signature/Credentials | Print Name | Date

Health-Medical Form: #04-0008
Reviewed Date: 7/1/2024
Policy Ref: #04-001-0065
EHR: Health Services, Other Health Documents Note: Medication Transfer