integrity compassion security respect

youth care center

A continuum of care

Prescription Medication Transfer Form

☐ SAFE/SECURE ☐ START ☐ STAGE

Resident Name: _____ Date: _____ Time: _____

Place of Transfer: _____

(Intake Staff): _____

(Releasing Staff): _____

Drug Name	Qty.	Int. / Person Receiving or Leaving Meds	Staff Int.	# of Refills	Refill Date

*** Staff and Person Receiving or Leaving Meds** - Both parties please count the number of pills present for all prescriptions at the time of transfer, initial where appropriate, and sign.

_____ _____

Person Receiving or Leaving Meds Phone Number