Connecticut Department of Children and Families

NOTIFICATION: Discontinuation Of A Psychotropic Medication (FAX TO: 1-877-DCF-DRUG)

DCF-465A

12/12 (Rev.)

Date: ______________ Time: ______________

Name of Child: ______________ Date of Birth: ______________ Gender: ______________

Prescriber: ______________ Tel # (cell): ______________

Return Response To: FAX #: ______________ E-mail: ______________

Contact Person (if not prescriber): ______________ Tel#: ______________

Child's Current Placement:

☐ Hospital ☐ Subacute/PRT ☐ Safe Home/Shelter ☐ Foster Home ☐ Detention/CJTS ☐ Residential ☐ Group Home

Name of Treatment Setting: ______________

Date Last Seen by Prescriber: ☐ Initial Assessment ☐ Follow Up Assessment Next Appointment:

Medications to be Discontinued	Current dosage and frequency	Reason for Discontinuation (Include adverse reactions, efficacy, other reasons)

NOTE: If child has had an allergic or adverse reaction to the medication, also complete and send a DCF-465B Suspected Adverse Drug Reaction Reporting Form.

You will not receive a written response to this notification. We ask that you include contact information in case we need additional information.

Provider Signature:	Date:

FAX TO: 1-877-DCF-DRUG or E-mail to getmeds@ct.gov