DPP-104C
(R.11/15)

Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Community Based Services
Division of Protection and Permanency

MEDICALLY COMPLEX MONTHLY REPORT

DATE:_____

Child's Name:_____ **Child's Birthdate:**_____
Foster Home:_____ **Date of Placement:**_____
Child's Weight:_____ **Height/Length:**_____

I. Overall Diagnosis and Care Needs:

II. Medications:

_____

_____

III. Physician(s) Name(s): **Area of Specialty:**

_____ _____

_____ _____

_____ _____

IV. Medical Appointments: Most Recent and Future:

V. Changes to Medications:

VI. Daily Medical Procedures/Treatment:

VII. Nutrition/Feeding Procedure:

_____

VIII. Medical Emergencies since Last Monthly Report: _____
IX. Services: Therapies (O.T., P.T., Speech, Infant Stimulation):

Medical Equipment Company: _____
School:_____
Commission Nurse Visit: _____**Home Health Visit:**_____
Counseling: _____
X. Family Visits: _____
XI. Comments or Concerns: _____

_____

_____ _____
Foster Parent Signature, Date Phone Number/Email Address

Provide Original to child's worker
Child's Worker sends copy to: *Medically* ***Complex*** *Liaison, R&C Worker and Designated CCSCHN nurse*