Controlled Drug Record

Residents Name:	DOB:	Room #

DATE	TIME	TABLETS CAPSULES AMPULES	SIGNATURE	DATE	TIME	TABLETS CAPSULES AMPULES	SIGNATURE	DATE	TIME	TABLETS CAPSULES AMPULES	SIGNATURE	DATE	TIME	TABLETS CAPSULES AMPULES	SIGNATURE

DISPOSITION OF REMAINING DOSES				MEDICATION INFORMATION	
☐ Doses transferred to a medical waste container				**MEDICATION ORDER:**	
Quantity	Date:	Signature	Witness:		
☐ Dose Discharged with patient	Date:	Quantity:	Name Receving Medication:	**DX:**	
SIGNATURE OF PARTY RECEIVING MEDICATION:	DATE:	No. of Doses Received:		**START DATE:**	**STOP/ DISCONTINUED DATE:**
PHYSICIAN PRESCRIBING MEDICATION:				**PHONE:**	**FAX:**