INDIVIDUAL NARCOTIC RECORD

LAST NAME	FIRST	MIDDLE INITIAL	FACILITY Room No. Bed
Name of Drug and Dose	Rx No.	Prescribing Physician	

Directions for Administration

Administration Route ☐ PO ☐ IM ☐ SQ ☐ IV ☐ Rectal ☐ Sublingual ☐ Transdermal/Patch ☐ Other____________

Date Received

Quantity Received

Received By

DATE	TIME	DOSE	AMOUNT REMAINING	NURSES SIGNATURE
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DISPOSITION OF UNUSED DRUG

Date Discontinued______________ Amount Remaining________ Nurse Signature/Title____ Date______________

Method of Disposition: ☐ Returned to Pharmacy Receiving Party Signature____ Date______________

Nurse Signature/Title____ Date______________

☐ Sent with patient at discharge. Patient/Responsible Party Signature____ Date______________

☐ Incinerated ☐ Mixed with coffee grounds ☐ Other:____

Nurse Signature/Title____ Date______________

Witness Signature/Title____ Date______________