

Date	Drug	Strength	Quantity	CONTROL NO.
Nursing Station	Received By (Nurse in Charge)		Date Rec'd.	Issued By

Form 1230 BRIGGS, Des Moines, IA 50306 (800) 247-2343

RECEIPT

DRUG ADMINISTRATION RECORD

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Date	Drug	Strength	Quantity	CONTROL NO.
Nursing Station	Received By (Nurse in Charge)	Date Rec'd.	Issued By	

DATE	TIME	PATIENT'S FULL NAME	ROOM NO.	MEDICATION	DOSAGE		DOCTOR	ADM. BY	BAL
					GIVEN	WASTED			
	AM PM								24
	AM PM								23
	AM PM								22
	AM PM								21
	AM PM								20
	AM PM								19
	AM PM								18
	AM PM								17
	AM PM								16
	AM PM								15
	AM PM								14
	AM PM								13
	AM PM								12
	AM PM								11
	AM PM								10
	AM PM								9
	AM PM								8
	AM PM								7
	AM PM								6
	AM PM								5
	AM PM								4
	AM PM								3
	AM PM								2
	AM PM								1
	AM PM								0

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RECORD OF WASTE AND SPOILAGE

Item	DATE	QUANTITY	DESCRIBE IN DETAIL	SIGNATURE #1	SIGNATURE #2

I hereby certify that the above doses were given as per written order by a physician on the treatment sheets of the above named patients.

DATE RETURNED _____ SIGNED _____