CONTROLLED DRUG ADMINISTRATION RECORD

Name of Drug/Strength/Dosage/Form:	Rx No.: Dispensing Pharmacy:	Directions for Use:

Prescribing Physician:

Administration Route:
❍ PO ❍ IM ❍ SQ ❍ IV ❍ Rectal
❍ Sublingual ❍ Transdermal/Patch

Date Received:_____ Qty Received:_____
Time Received:_____ ❍ AM ❍ PM
Received From:_____
(Signature of person delivering)
Received By:_____

Stored in Resident's Apt/Room? ❍ No ❍ Yes
If Yes, Received By:

_____ _____
Resident Signature *Date*

DATE	TIME	DOSE	SIGNATURE	AMOUNT REMAINING	WITNESSED BY	DATE & TIME

DISPOSITION OF UNUSED DRUG

Discontinue Date:_____ Amount Remaining:_____ Witness Signature:_____

Date of Disposition:_____ Time:_____ ❍ AM ❍ PM Witness Signature:_____

Method of Disposition:_____ Witness Signature:_____

NAME–Last	First	Middle	Attending Physician	Record No.	Room/Bed