INDIVIDUAL NARCOTIC RECORD

NAME OF FACILITY

DIRECTIONS FOR USAGE

1. Please write legibly. Make entries in blue or black ink only. This is a permanent record.
2. Do not erase or attempt to use ink eradicator. If an error is made, draw a single line through the error and enter "Written in error by_________." Sign and date each correction.
3. Each page of the book is numbered. The book is designed to be kept together as one book so do not tear out any pages.
4. On the Index Page, enter the name of the patient, the name of the physician who prescribed the drug, the name and Rx number of the drug and the date the drug was received.
5. Record the date the drug was discontinued in the last column of the Index Page.
6. On the Individual Narcotic Record pages, enter all of the information called for, with special attention to accurately record "Directions for Usage" as prescribed by the physician.
7. Use a separate page for each drug of an individual patient.
8. Upon the discharge of the patient or upon any discontinuance of the use of the drug, the date of discontinuance, the amount of the drug remaining and its disposition should be entered at the bottom of each page. Each entry should be accompanied by an authorized signature.
9. The Controlled Drugs-Count Record is provided for shift verification. Record the date and shift of each count. The nurse leaving the shift and the nurse starting the shift perform the count and sign accordingly. Record discrepancies or pertinent notes in the Comments section.

DO NOT DESTROY THIS BOOK
IT IS TO REMAIN A PART OF THE PERMANENT RECORDS
OF THE FACILITY

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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
	❍ AM ❍ PM			
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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_______________

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INDIVIDUAL NARCOTIC RECORD

LAST NAME	FIRST	MIDDLE INITIAL	FACILITY Room No. Bed

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Nurse Signature/Title____ Date______________

Witness Signature/Title____ Date______________

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CONTROLLED DRUGS–COUNT RECORD

Month_________________ Year___________

FACILITY____ UNIT____________________________

Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record. Record any discrepancies or pertinent notes in COMMENTS.

DATE	SHIFT	NURSE ON SIGNATURE	NURSE OFF SIGNATURE	COMMENTS
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CONTROLLED DRUGS–COUNT RECORD

Month________________ Year__________

FACILITY____ UNIT___________________________

Signing below acknowledges that you have counted the controlled drugs on hand and have found that the quantity of each medication counted is in agreement with the quantity stated on the Controlled Drug Administration Record. Record any discrepancies or pertinent notes in COMMENTS.

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