CONTROLLED MEDICATION ADMINISTRATION RECORD

Medication Name:______________________________ Dosage:____________ Amount Ordered:____________

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

Directions for Use:______________________________________ Prescribed by:________________________

Prescription No.:______________________ Pharmacy:____

DATE	TIME	AMOUNT RECEIVED	AMOUNT ON HAND	AMOUNT ADMIN'D.	AMOUNT REMAINING	SIGNATURE OF NURSE	VERIFICATION BY SIGNATURE/DATE/TIME
	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM
	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM
	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM
	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM
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	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM

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

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CONTROLLED MEDICATION ADMINISTRATION RECORD

❑ Continued on Reverse

CONTROLLED MEDICATION ADMINISTRATION RECORD

DATE	TIME	AMOUNT RECEIVED	AMOUNT ON HAND	AMOUNT ADMIN'D.	AMOUNT REMAINING	SIGNATURE OF NURSE	VERIFICATION BY SIGNATURE/DATE/TIME
	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM
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	❍ AM ❍ PM						Date: Time: ❍ AM ❍ PM

DISPOSITION OF UNUSED MEDICATION

Date Discontinued:_______________ Amount Remaining:________

Nurse Signature/Title:____ Date:_______________

Method of Disposition: ❍ Returned to Pharmacy

Receiving Party Signature:____ Date:_______________

Nurse Signature/Title:____ Date:_______________

Method of Disposition: ❍ Sent with patient at discharge

Patient/Responsible Party Signature:____ Date:_______________

Nurse Signature/Title:____ Date:_______________

Method of Disposition: ❍ Incinerated ❍ Mixed with coffee grounds ❍ Other:_______________________

Nurse Signature/Title:____ Date:_______________

Witness Signature/Title:____ Date:_______________

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

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