



Patient's Own Medication – **CONTROLLED SUBSTANCE Administration** Log

****PHARMACY RECEIPT****

Date: _____ Time: _____

Patient Name: _____ DOB: _____ FIN: _____

Drug Name: _____ Drug Strength: _____ Dosage Form: _____

Starting Quantity on Hand: _____ Pharmacist Initials: _____ Pharmacist/Tech Initials: _____

Delivered By: _____ Received By: _____

Receipt shall be retained by pharmacy and matched with completed log CONTROLLED SUBSTANCE Administration Log upon patient transfer/discharge.



Patient's Own Medication – CONTROLLED SUBSTANCE Administration Log

Patient Name (Last, First) & DOB	Drug Name	Drug Strength and Form	Pharmacist Initials	Nurse Initials	Starting Quantity on Hand

Date	Time	Drug Name	Dose		RN Signature	RN Signature (Waste)	Remaining Quantity Remaining
			Given	Wasted			

RETURN TO PHARMACY WHEN PATIENT DISCHARGED/TRANSFERRED. PHARMACY TO KEEP WITH CONTROLLED SUBSTANCE DOCUMENTATION.

Date	Time	Drug Name	Dose		RN Signature	RN Signature (Waste)	Remaining Quantity Remaining
			Given	Wasted			

RETURN TO PHARMACY WHEN PATIENT DISCHARGED/TRANSFERRED. PHARMACY TO KEEP WITH CONTROLLED SUBSTANCE DOCUMENTATION.