MONTH ___________________ YEAR _______

NAME ________________________________ PHARMACY ______________________________________ PHONE _________________

ALLERGIES ______________________________

______________________________________ PRIMARY PHYSICIAN ______________________________ PHONE _________________

CODE:	
R	**Refused**
A	**Absent**
C	**See Comments**
D	**Discontinued**

Administration

MEDICATION/STRENGTH: **PRESCRIBING MD (if different):** **PHONE:**

Schedule:

☐ Oral ☐Topical ☐ Other

RX #

Special Instructions:

Purpose:

☐ Controlled Substance

Time	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Comments/Observations

Inventory

Refill Received:

RX #

Number Received:

Verified By:

If Med Error is marked, fill out an Incident Report

Refill bottle to be inventoried then it should remain unopened until needed.

Count:																															
# Given																															
# Left																															
Initials																															
Med Error																															

Comments:

Administration

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Med Error																															

Comments:

Initials/Signature ____ Record Number _____ of _____ Check if Record is Completed □