CONSUMER MEDICATION BROUGHT FROM HOME

UNIT ______________________________ DATE __________

CONSUMER'S NAME ______________________________

	Medication Name	Description (i.e. blue tablet or capsule)	Quantity	Pharmacy Verification of Quantity
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

DISPOSITION:

Admission Staff Name/Signature ______________________________ Date/Time __________

Ward/Living Unit Nurse Name/Signature ______________________________ Date/Time __________

Name/Signature of Nurse Sending Med to Pharmacy ______________________________ Date/Time __________

Quantity verified in Pharmacy by ______________________________ Date __________

DATE RETURNED TO LIVING UNIT __________ AUTHORIZING M.D. ______________________________

DATE PICKED UP BY CONSUMER __________ AUTHORIZING M.D. ______________________________

____

Name and Signature of Person Receiving Medication(s)

DATE MAILED TO CONSUMER __________ AUTHORIZING M.D. ______________________________

DATE DESTROYED BY PHARMACY__________ PHARMACIST ______________________________

CONSUMER MEDICATION BROUGHT FROM HOME

UNIT______________________________ DATE ___________

CONSUMER'S NAME ______________________________________

	Medication Name	Description (i.e. blue tablet or capsule)	Quantity	Pharmacy Verification of Quantity
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

DISPOSITION:

Admission Staff Name/Signature ____ Date/Time ____________

Ward/Living Unit Nurse Name/Signature ____ Date/Time ___________

Name/Signature of Nurse Sending Med to Pharmacy ____________________________ Date/Time ___________

Quantity verified in Pharmacy by ____ Date ____________

DATE RETURNED TO LIVING UNIT _________ AUTHORIZING M.D. ___________________________________

DATE PICKED UP BY CONSUMER __________ AUTHORIZING M.D. _____________ ______________________

____

Name and Signature of Person Receiving Medication(s)

DATE MAILED TO CONSUMER _____________ AUTHORIZING M.D. ___________________________________

DATE DESTROYED BY PHARMACY__________ PHARMACIST ____