RxAdvantage
Patient Safety Through Innovation

Non-Control Packet Medication Destruction

Facility Name:_____ **Date of Destruction:**_____

Facility Address:_____

Pharmacy Name / Address Rx # Patient Name Medication/Strength Adhere Label Here	Pharmacy Name / Address Rx # Patient Name Medication/Strength Adhere Label Here	Pharmacy Name / Address Rx # Patient Name Medication/Strength Adhere Label Here
Reason: Qty:	Reason: Qty:	Reason: Qty:
Pharmacy Name / Address Rx # Patient Name Medication/Strength Adhere Label Here	Pharmacy Name / Address Rx # Patient Name Medication/Strength Adhere Label Here	Pharmacy Name / Address Rx # Patient Name Medication/Strength Adhere Label Here
Reason: Qty:	Reason: Qty:	Reason: Qty:
Destruction by: Outside Pick Up:_____ Flushing:_____ Other:_____	_____ Signature of Pharmacist	_____ Signature of Charge Nurse
Reason for Destruction: 1- Resident d/cd 3-Med d/cd 2-Resident exp'd 4-Med exp'd	Pharmacy: 1. RxAdvantage 2._____	_____ Signature of Nurse Witness