RXAdvantage

FACILITY _____

DISPOSITION OF MEDICATIONS FORM

Resident's Name _____ Room # _____

	RX #	DRUG NAME	AMOUNT	LABEL DATE
1				
2				
3				
4				
5				
6				
7				
8				

TYPE OF DISPOSITION (MUST CHECK ONE)

☐ Discharged with drugs

☐ To Nursing Office for disposal (control drugs)

☐ Destroyed

☐ Doses Removed From Emergency Drug Kit.

DISCHARGED WITH DRUGS

Signature of Nurse Releasing Medication: _____

I hereby accept medication(s) in non-childproof containers for the person in which they were prescribed. Medication(s) released will be submitted for payment per the Agreement for Pharmaceutical Services.

Signature of person accepting medication: _____

TO NURSING OFFICE FOR DISPOSAL (CONTROL DRUGS)

Signature of Nurse Releasing Medication: _____

Signature of D.O.N. Receiving Medication: _____

NON-CONTROLLED DRUGS DESTROYED BY NURSING

DESTROYED BY (Signature): _____

Witness:_____