CONTROLLED SUBSTANCE DELIVERY RECORD

REV 04/19

Verbal authorization was given by the Head of Nursing (HoN) or designee to ______________________ to pick up and deliver the following Controlled Substances:

(HPH Staff Name)

____________________________ at _______ a/pm on ___________.

(Name of HoN or designee)                  (Time)                    (Date)

______________________________        __________________

Signature of HoN or designee                                                    Date

A. The following controlled substance(s) were picked up at: ______________________

(Pharmacy Name/Location)

Medication ___________________________ Quantity ___________

Medication ___________________________ Quantity ___________

Medication ___________________________ Quantity ___________

Pharmacy’s Representative_______________________Date_________/Time______a/pm

Hospice Representative_______________________Date_______/Time ______a/pm

B. The following controlled substance(s) have been delivered to: __________________

(Patient’s Name)

____________________________________________ Medication ________ Quantity

Medication ___________________________ Quantity ___________

Medication ___________________________ Quantity ___________

Patient/Patient’s Representative_______________________Date_______/Time______a/pm

Hospice Representative_______________________Date _____/Time_____a/pm