INDIVIDUAL RESIDENT'S CONTROLLED SUBSTANCE RECORD

Medication Name	Medication #	Dosage	Method of Administration	Pharmacist Name

Amount Ordered	Amount Received	Signature of Nurse Receiving Medication	Date

DISPOSITION OF REMAINING DOSES - Per Facility Policy

- ☐ Doses transferred to a Federally approved medical waste receptacle
- ☐ Doses flushed
- ☐ Doses incinerated
- ☐ Doses mixed with cat litter/ coffee grounds
- ☐ Other: _____

Quantity	Date

Nurse Signature

Witness Signature	Title

☐ Doses Transferred to other Disposal Record — Date

Signature	Title

OPTIONAL BOX FOR LABEL

☐ Doses Discharged with Resident (See Record on Chart) — Quantity — Date

☐ Party Receiving (*See Discharge Note) — Nurse Signature

NAME OF PERSON GIVING	DATE	TIME	AMT. ON HAND	AMT. RECEIVED	AMT. GIVEN	AMT. REMAINING

Resident Name	ID #	Room #	Physician

Form # MP5211 (Rev. 01/15)

Reorder From: MED-PASS® 800-438-8864

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Resident Name | ID # | Room # | Physician

NAME OF PERSON GIVING	DATE	TIME	AMT. ON HAND	AMT. RECEIVED	AMT. GIVEN	AMT. REMAINING

DATE	TIME	AMT. ON HAND	AMT. RECEIVED	AMT. GIVEN	AMT. REMAINING	NAME OF PERSON GIVING

Resident Name | ID # | Room # | Physician

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