Centrally Stored Medication and Destruction Record

REQUIRED FORM:

This form is a required document in client file for detox and residential programs

WHEN:

Completed at Screening/Intake Admission

COMPLETED BY:

Completed by authorized agency representative

REQUIRED ELEMENTS:

Centrally Stored Medication Instruction:

- **Resident's Name:** Complete client's full name.
- **Admission Date:** Complete the client's date of admission.
- **Attending Physician:** Complete the name of the client's primary physician.
- **Facility Name:** Complete the name of the program.
- **Facility ID Number:** This number will be provided by your agency.
- **Program Director:** Complete the full name of the program director.
- **Medication Name:** Complete the name of the medication as stated on the medication label.
- **Strength/Quantity:** List the strength and the amount of the medication brought in at the time of admission (e.g., 20mg/30 pills).
- **Instructions/ Control/Custody:** List directions for the administration of the medication as prescribed by the physician.
- **Expiration Date:** Document the medication's expiration date as stated on the medication label.
- **Date Filled:** Document the date prescription was filled as stated on the medication label.
- **Prescribing Physician:** Document the name of the physician prescribing the medication as stated on the medication label.
- **Prescription Number:** Document the prescription number as stated on the medication label.
- **Number of Refills:** Document the number of refills as stated on the medication label.
- **Name of Pharmacy:** Document the name of pharmacy which filled the prescription.

Medication Destruction Record Instruction:

- **Medication Name:** Complete the name of the medication as stated on the medication label.
- **Strength/Quantity:** List the strength and the amount of the medication to be destroyed (e.g., 20mg/30 pills).
- **Date Filled:** Document the date prescription was filled as stated on the medication label.

- **Prescription Number:** Document the prescription number as stated on the medication label.
- **Disposal Date:** Document the actual disposal date of the medication as outlined by the agency's policies and procedures.
- **Name of Pharmacy:** Document the name of pharmacy which filled the prescription.
- **Administrator's Signature:** The administrator of the agency responsible for the disposal of the medications must sign.
- **Witness' Signature:** Staff member other than the administrator witnessing the disposal of the medications must sign.

NOTE:

For additional space, you may duplicate this form.