EVERGREEN
SERVICE PROVIDERS

INDIVIDUAL CONTROLLED DRUG RECORD

Receipt / Record / Disposition Form

Individuals Name: Pharmacy:

Name of Medications: RX#:

Directions for use: Quantity Received:

Ordered by Physician: Date Received/HHP-Staff Initials:

EACH DOSE SIGNED FOR HERE REQUIRES CHARTING ON THE MEDICATION RECORD – MAR

DATE	TIME	AMOUNT GIVEN	AMOUNT REMAINING	HOST HOME PROVIDER or STAFF SIGNATURE

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