

CONTROLLED MEDICATION DISPOSAL LOG

Psychiatric Health Facility

PATIENT NAME	MEDICATION Name/ Strength	RX#	AMOUNT DISPOSED	REASON FOR DISPOSAL	Waste		Destruction	
					DATE DISPOSED	DISPOSED OF BY + Witness (signatures)	DATE / PHARMACIST + RN WITNESS (signatures) ON REMOVAL	

DRAFT

This form is to be used when TWO LICENSED STAFF are disposing ("WASTING") of a **CONTROLLED medication
7.31.2017 AS