SANTA BARBARA COUNTY
DEPARTMENT OF
Behavioral Wellness
A System of Care and Recovery

NON-CONTROLLED MEDICATION DISPOSAL LOG

Psychiatric Health Facility

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

draft

***This form is to be used for NON-CONTROLLED medication disposal ("WASTE") - two licensed staff signatures required

7.31.2017. AS