NDP 17 2/25 CONTROLLED SUBSTANCE SIGN OUT SHEET

Optional

Agency Name _____

This sheet is to be completed each time a controlled substance is removed from the blister pack or bottle

Medication Name/Dosage: _____ Administration Time(s):_____
Month_____Year_____Beginning Count:_____ Nurse Signature: _____

Name of Person:	**Health Care Practitioner**:

	Date	Time	# Present	# Given	# Remaining	Signature and Credentials	Comments

Agency must have a form of documentation that records controlled medication count whenever medication is removed from pharmacy packaging. May use this form or their Agency version of form. Agency must have a procedure for review & reconciliation by the MAS Nurse.