



**RECORD OF MEDICATION
RECEIPT/STORAGE, ADMINISTRATION & DISPOSAL (CONTROLLED SUBSTANCES)**

HEALTH CARE AGENCY
BEHAVIORAL HEALTH SERVICES
COUNTY OF ORANGE, CALIFORNIA

CLINIC NAME & ADDRESS: _____

DO NOT LEAVE ANY ITEMS BLANK. EITHER CROSS OUT OR INDICATE N/A

RECEIPT						ADMINISTRATION (Also document in individual patient chart/EHR clinical record)				DISPOSAL (DESTROYED)/ RETURN			
Date Ordered	Date Received / Expiration Date / Administer By Date	Medication Name, Amount and Quantity (Include Lot #)	Name of Dispensing Pharmacy or PAP (Drug Manufacturer)	Patient Name	Two Signatures REQUIRED (Medical Licensed Staff and Witness)	Date & Time	Dose Administered	Route of Administration	Signature & License of Medical Staff Administering Medication	Date	Medication Dose / Amount Destroyed or Returned	Type	Two Signatures REQUIRED (Medical Licensed Staff and Witness)
	Date Received Expiration Date Administer By Date											<input type="checkbox"/> Destroyed <input type="checkbox"/> Return to Pharmacy _____ Name	
	Date Received Expiration Date Administer By Date											<input type="checkbox"/> Destroyed <input type="checkbox"/> Return to Pharmacy _____ Name	
	Date Received Expiration Date Administer By Date											<input type="checkbox"/> Destroyed <input type="checkbox"/> Return to Pharmacy _____ Name	
	Date Received Expiration Date Administer By Date											<input type="checkbox"/> Destroyed <input type="checkbox"/> Return to Pharmacy _____ Name	