Controlled Medication Count

Individual's Name: ____________________ Program: ______________________

Medication: __________________________ Dosage: _______________________

Time to be Given: _____________________ Rx#: __________________________

Prescribing Physician: __________________ Amount Received: ______________

DATE	SHIFT	TIME	REASON FOR COUNT	STAFF SIGNATURE (S)	COUNT
			☐ **Shift Count** ☐ **Dose Given**		
			☐ **Shift Count** ☐ **Dose Given**		
			☐ **Shift Count** ☐ **Dose Given**		
			☐ **Shift Count** ☐ **Dose Given**		
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