CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM

GIL DRUGS

Rx#	**Date Received**
Pt Name	**Doctor**
Drug Name/Strength	
Directions	
Pharmacy	**Quantity Received** **Admin Time**

Signature of nurse receiving medication

No. of Doses Date

Each dose signed for here requires charting on the medication record

Disposition of Remaining Doses

[ ] Doses flushed Quantity: ______ Date: ______

RN Signature: ______

Rph Signature/Witness: ______

Date	Time	Amount Given	Amount Left	Signature

Date	Time	Amount Given	Amount Left	Signature

Date	Time	Amount Given	Amount Left	Signature

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Date	Time	Amount		Signature	Date	Time	Amount		Signature	Date	Time	Amount		Signature
		Given	Left				Given	Left				Given	Left	