PENINSULAS EMS COUNCIL REGIONAL MEDICATION USE/WASTAGE FORM

MO/DAY/YEAR ______/______/______ AGENCY INCIDENT NUMBER ____________ EMS AGENCY NAME: ____________

PATIENT NAME (Last, First, M.) ____________ PATIENT CARE RECORD # ____________

SSN ____________ DOB ____________ OLD DRUG BOX NUMBER ____________

CHIEF COMPLAINT ____________ NEW DRUG BOX NUMBER ____________

MEDICATION	DOSE/AMOUNT USED	MEDICATION	DOSE/AMOUNT USED

NARCOTIC WASTED IN EMERGENCY DEPARTMENT	DOSE/AMOUNT	LICENSED PRACTITIONER SIGNATURE

CREW MEMBER PRINTED NAME (Last, First, M.) ____________ CREW MEMBER SIGNATURE ____________

Physician Signature (Only required for medications given outside protocols or for narcotic use) ____________ Date ____________

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