CONTROLLED SUBSTANCE DESTRUCTION FORM

Name ____________________
Address____________________

Resident: ________________
RX #: ___________________
Pharmacy: _______________
Medication:______________
Strength:________________
Dosage Form:_____________
# of Dosage Units: ________

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RX #: ___________________
Pharmacy: _______________
Medication:______________
Strength:________________
Dosage Form:_____________
# of Dosage Units: ________

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RX #: ___________________
Pharmacy: _______________
Medication:______________
Strength:________________
Dosage Form: ____________
# of Dosage Units: ________

Date:____________________

Method of
Destruction:_______________

Administrator:_______________

D.O.N.:____________________

CRPh:_____________________