

UNUSED MEDICATION TRACKING SHEET

NOTE:

- Document wasted/unused controlled medications on the *Controlled Medications Record* form.
- Place completed form with your medication disposal policy

Date	Drug Name	Form*	Strength	Amount^	Disposal Method	Staff/Witness Signatures
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						

*Forms include tablet, capsule, vial, cream, gel, emulsion, inhalant, patch, lollipop, suppository, liquid, etc.

^Amount wasted: number of items or liquid volume

CONTROLLED MEDICATION RECORD

Resident's Name: _____ Date Received: _____

Prescriber: _____ Prescription #: _____

Medication: _____ Strength: _____ Dosage: _____ Form: _____

Directions: _____ Amount Received: _____

	Date	Time	Current Amount	Amount Given	Amount Left	Signature
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						
18.						
19.						
20.						
21.						
22.						
23.						

Discrepancy Notes:

Destruction Record

Destruction Needed? ____ Yes ____ No (All medication distributed) Date of Destruction: _____

Amount Destroyed: _____ Method of Destruction: _____

Signature #1: _____ Signature #2: _____

Medication Safety Questionnaire			
<i>Resident's Name:</i>			
Medication	<i>Dose and Form:</i>	<i>When to take each dose:</i>	<i>For how long?</i>
<i>Brand Name:</i>			
<i>Generic Name:</i>			
1. <i>What is the purpose of the medication? What is it being prescribed for?</i>			
2. <i>Are there any special administration instructions (for example, take before/after meals, with food)?</i>			
3. <i>What is the medication supposed to do? How will I know it is working?</i>			
4. <i>How long before I will know it is working or not?</i>			
5. <i>Is there any lab work that will need to be scheduled? Yes/No</i> a. <i>How often?</i> b. <i>Where?</i> c. <i>Will there be a standing order?</i>			
6. <i>What should I do if the resident misses a dose?</i>			
7. <i>How should this medication be stored? Is this a controlled medication? Yes/No</i>			
Interactions			
8. <i>Should this medication be taken with food? Yes/No</i> a. <i>If yes; before, during or after the meal?</i> b. <i>If yes; an hour before or two hours after the meal?</i>			
9. <i>Are there any foods, supplements (such as herbs, vitamins, minerals), drinks (for example: drinks with alcohol or caffeine), or activities that should be avoided (for example: avoid being out in the sun) while taking this medication?</i>			
10. <i>Are there OTC medications that should be avoided? Yes/No - If yes, which ones:</i>			
Side Effects			
11. <i>What are the common side effects?</i>			
12. <i>If there are side effects, what should I do?</i>			
13. <i>Are there any long-term effects if prescribed for a long time? Yes/No</i>			