Preferred Care
Pharmacy

PATIENT NAME ______________________________

MEDICATION ________________ QUANTITY __________

RX NUMBER ____________ DOCTOR ____________

STAFF RECEIVING MEDICATION __________ DATE ________

DATE	TIME	DOSE	STAFF ADMINISTERING	AMOUNT WASTED	CO-SIGNATURE	AMT LEFT

Date any amount returned to pharmacy ______________ Staff Signature ______________________

Amount returned to pharmacy ______________ Co-Signature ______________________

Source: ~ dt-billing
Original document #: 437290 received on 6/20/2017 4:23 PM EDT