INSTRUCTIONS:
Apply Rx label or complete order information in area provided. Signature required by nurse receiving and verifying quantity received. Full signature required for each administration of controlled drug.
Document wasted doses on side two.

PharMerica
Value. Trust. Performance.

ANTIBIOTIC DRUG RECORD
(Wide Format)

Tablets - Capsules - Ampules - Liquids - (Maximum Dispensed 124 Units - Minimum Dosage 1 Unit)

Date	Time	No.	Signature	Date	Time	No.	Signature	Date	Time	No.	Signature	Date	Time	No.	Signature
		124				93				62				31	
		123				92				61				30	
		122				91				60				29	
		121				90				59				28	
		120				89				58				27	
		119				88				57				26	
		118				87				56				25	
		117				86				55				24	
		116				85				54				23	
		115				84				53				22	
		114				83				52				21	
		113				82				51				20	
		112				81				50				19	
		111				80				49				18	
		110				79				48				17	
		109				78				47				16	
		108				77				46		7/15	0940	15	
		107				76				45		7/15	1300	14	
		106				75				44		7/15	1700	13	
		105				74				43		07/16	0847	12	
		104				73				42		7/16	1240	11	
		103				72				41		7/16	1659	10	
		102				71				40		7/17	0900	9	
		101				70				39		7/17	1300	8	
		100				69				38		7/17	5PM	7	
		99				68				37		7/18	08	6	
		98				67				36		7/18	13	5	
		97				66				35		7/18	1700	4	
		96				65				34		07/19	1217	3	
		95				64				33		7/19	700	2	
		94				63				32				1	

RX NO.
NAME
DRUG NAME/STRENGTH
DIRECTIONS
DOCTOR
PHARMACY

5284011.00 7/14/23 358 PAVSU/3/337/B
CAO,HO V QTY: 15.000
ephALEXin 500 MG CAPSULE 68180-122-02
Generic For:KEFLEX 500 MG CAPSULE
IVE 1 CAPSULE BY MOUTH THREE TIMES A DAY FOR UTI
OR 5 DAYS
PELLEGRINO.MARK BP2564929
7542 17TH ST STE 320 TUSTIN CA 92780 -000-0000
1 of 3

NOTE ON LIQUIDS:

# of cc Dispensed _____ = _____ # of Doses
# of cc/Dose _____ (Starting point on this form.)

EXAMPLE:
# of cc Dispensed 60 = 24 # of Doses
# of cc/Dose 2.5

*** DISCHARGE NOTE FOR PERSON RECEIVING MEDICATIONS:**
My signature on this form is indication that I do not want these medications in child proof containers and I understand that if I do want the child proof containers I may return these drugs to the issuing pharmacy for repackaging.
Also, directions for use of all medication I received have been discussed with me.

DEPOSITION OF REMAINING DOSES

☐ Doses disposed Method _____ Quantity 15 Date _____
Signature/Title _____ LVN Signature/Title _____ LVN

☐ Doses transferred to other Disposal Record

☐ Doses discharged with patient *(SEE RECORD ON CHART)*.

☐ Doses discharged with patient Quantity 15 Date _____
Party Receiving* _____ Nurse _____

Total Amount Received	Amount This Sheet	☐ PharMerica ☐ Other: _____
Received By ▶		Date Received