

CENTRAL STATE HOSPITAL
REPORT OF CONTROL DRUG LOSS OR WASTE

DATE _____

FACILITY, BUILDING & LIVING UNIT/WARD _____

REGISTRATION NUMBER OF SIGNOUT SHEET _____ BLOCK NUMBER _____

NAME OF DRUG _____ QUANTITY _____

CONTROLLED DRUG WAS:	BROKEN	<input type="checkbox"/>
	WASTED ACCIDENTALLY	<input type="checkbox"/>
	UNEXPLAINED LOSS	<input type="checkbox"/>
	OTHER	<input type="checkbox"/>

EXPLICIT STATEMENT OF WHAT HAPPENED. (INCLUDE NAME IF APPLICABLE)

DATE AND TIME LOSS WAS DISCOVERED _____

SIGNATURE AND TITLE OF PERSON RESPONSIBLE _____

SIGNATURE OF WITNESS _____

AS THE IMMEDIATE SUPERVISOR OF THE PERSON INVLOVED, OR AS THE PERSON IMMEDIATLEY RESPONSIBLE FOR THE DRUGS ON THIS LIVING UNIT, I ACKNOWLEDGE THIS REPORT.

NAME & TITLE _____

DATE _____

REVIEW BY PHARMACIST _____

DATE _____