TEMS PHARMACY EXCHANGE FORM

EMS Agency: _____
(Printed)

Incident #_____

Unit #_____

Date: _____

Patient Name_____
& MRN_____
or cover w/ PATIENT STICKER

EMS Provider Printed Name: _____

EMS Provider Signature: _____

Used IV Box #: _____ Used Medication Box #: _____

New IV Box #: _____ New Medication Box #: _____

Controlled Substance Documentation: (If Applicable)

Drug	Amount Administered	Amount Wasted	Waste Witness Name/Signature
Fentanyl (Sublimaze)			
Lorazepam (Ativan)			
Midazolam (Versed)			
Morphine			

Physician Signature: _____

Technician Signature: _____

Revised: 7/7/17

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