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 Given	Amount Wasted	Waste Witness Name/Signature
Sublimaze (Fentanyl) 100mcg/2ml x 2			
Ketamine 500mg/10ml x 1			
Midazolam (Versed) 5mg/1ml x 3			
Morphine 10mg/1ml x 2			

REMAINING CONTROLLED SUBSTANCES ACCOUNTED FOR: YES / NO

Physician Signature: ____________________________________
Technician Signature: ___________________________________

Revised: April 2020

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Revised: April 2020