CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

INSTRUCTIONS:	is not accessible to any person(s) except authorized individuals. Medication									Facility Name: Facility Number:		
Name: (Last	records for each client/reside First Middl				Attending Physician:				Administrator:			
Medication Name	Strength/ Quantity	Instructions Control/Custody	Expirati Date			Date tarted	Prescribing Physician		cription Imber	No. of Refills	Name of Pharmacy	
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Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date Started	Prescribing Physician	Prescription Number	No. of Refills	Name of Pharmacy

II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: For facilities other than Residential Care Facilities for the Chronically III (RCFCI) and Residential Care Facilities for the Elderly (RCFE), prescription medication that is not taken with a client or resident when services are terminated or otherwise disposed of must be destroyed in the facility by the administrator or designated representative and witnessed by one other adult who is not a client or resident. Medication destruction records must be retained for at least one (1) year.

For **RCF-CIs**: Prescription medication that is not taken with a resident when placement is terminated or which is not to be retained must be destroyed by the administrator and the facility manager. Medication destruction records must be retained for at least three (3) years.

For **RCFEs:** Prescription medications which are not taken with a resident when services are terminated, not returned to the issuing pharmacy, not retained in the facility as ordered by the resident's physician and documented in the resident's record, not disposed of according to the established procedures of a hospice agency, or not otherwise disposed of must be destroyed by the administrator and one other adult who is not a resident of the RCFE, in the RCFE. Records documenting destruction of medication must be retained for at least three (3) years.

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident