DOCUMENTATION OF DRUG DISPOSAL

Date: ______________

Member’s Name: ________________________________

Provider Name: ________________________________

Name of Medication (as it appears on medication):
______________________________________________________

Type of Medication:
☐ Pills
☐ Cream
☐ Liquid
☐ Syringe
☐ Other ____________________________

Provider Initials: ______  Count: _______
Ariel Staff Initials: _____  Count: _______

Reason for Disposal:
☐ Discontinued
☐ Change in Prescription
☐ Client Refusal
☐ Soiled
☐ Other: _______________________________________

To be completed at time of disposal:

Count confirmed: ______________

Designated Staff Signature: ____________________________  Date: _____________

Designated Staff Signature: ____________________________  Date: _____________

Revised 7/1/2019