



# DOCUMENTATION OF DRUG DISPOSAL

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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: \_\_\_\_\_