

MANAGEMENT AND DISPOSAL OF CONTROLLED SUBSTANCES IN THE HOME

**Patient Name**:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NAME OF MEDICATION** | **NUMBER OF****TABLETS/CAPSULES** | **MLS OF LIQUID MEDICATION** | **WITNESS SIGNATURE** | **NURSE VERIFICATION** |
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 Signature of Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Verifying Nurse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Option for GEORGIA residents only:**

**Family declines assistance with disposal of controlled substances**

 Reviewed 04/2019

 Revised 07/2018