

WPAHS Facility

- ___ AGH
- ___ AGH-Suburban Campus
- ___ AKMC
- ___ CGH
- ___ WPH
- ___ WPH-Forbes Campus



Must be filled out by Service Medic.

ALS Service: _____

Completed By: _____

Certification #: _____

Date: ____ / ____ / ____

CC # and Name : _____

Signature of person receiving Medications: _____

Controlled Substance Replacement Form

Choose ***only*** one per form:

Medication		Unit of Measure	Dosage	Ex-change (count)	Replace (count)	New (count)
Diazepam	<i>Valium</i>	Vial	10 mg/2 ml			
Etomidate	<i>Amidate</i>	Vial	40 mg/20 ml			
Fentanyl	<i>Sublimaze</i>	Vial	.10 mcg/2 mL			
Morphine Sulfate		Carpject	2 mg/1 ml			
Midazolam	<i>Versed</i>	Vial	2 mg/2 ml			

Patient information:

Check one:

- Protocol MD Order

Name _____ Trip Sheet # : _____

Dose Administered: _____

Date Administered: _____ Time Administered: _____

Paramedic Administering: _____ State Cert. # _____
(Signature)

Medic Command Physician ORDERING Medication:

(Name)

(DOH Number)

Person Witnessing Disposal of Unused Drug: _____

(Signature)

Pharmacy information:

Pharmacist/RN Issuing Replacement: _____
(Signature)

Paramedic Receiving Replacement: _____
(Signature)

Date of Replacement: _____

**** PCR required to be delivered to EMS Coordinator within 24 hours****

Physician: _____
DEA Number: _____