St. Clair County Community Mental Health

Disposal of Medications

NAME: ____ CASE #: ____________________

MEDICATION: ____

DOSAGE: ____

NUMBER OF TABLETS, CAPSULES: _________________________ LIQUID (Approximate): ______________________

REASON FOR DISPOSAL: ____

HOW IT WAS DISPOSED OF: ____

TIME AND DATE: ____

NURSE SIGNATURE: ____

NURSE PRINT: ____

WITNESS SIGNATURE: ____

WITNESS PRINT: ____

MEDICATION: ____

DOSAGE: ____

NUMBER OF TABLETS, CAPSULES: _________________________ LIQUID (Approximate): ______________________

REASON FOR DISPOSAL: ____

HOW IT WAS DISPOSED OF: ____

TIME AND DATE: ____

NURSE SIGNATURE: ____

NURSE PRINT: ____

WITNESS SIGNATURE: ____

WITNESS PRINT: ____

MEDICATION: ____

DOSAGE: ____

NUMBER OF TABLETS, CAPSULES: _________________________ LIQUID (Approximate): ______________________

REASON FOR DISPOSAL: ____

HOW IT WAS DISPOSED OF: ____

TIME AND DATE: ____

NURSE SIGNATURE: ____

NURSE PRINT: ____

WITNESS SIGNATURE: ____

WITNESS PRINT: ____

cc: Home Provider

Health-Medical Form: #04-0305
Reviewed Date: 7/1/2024
Admin Procedure Ref: #04-001-0050
EHR: Health Services, Other Health Documents Note: Disposal of Medications