CONTROLLED MEDICATION COUNT SHEET

Client:_____ Physician:_____

Medication, Strength, & Dosage:_____

Amount Received: Quantity of liquid or # pills_____AND # of doses_____ Date Received_____

Date:_____ Starting Balance:_____ ***(Indicate # of doses or amount of liquid)***

Signature of Person Preparing Record:_____

Date-1-15th, Year	Time	Amt. Given Amt. of liquid/dose	Balance on hand/amt. of liquid/doses left	Full Signature of person assisting with medication	Date 16-31st, Year	Time	Amt. Given Amt. of liquid/dose	Balance on hand/amt. of liquid/doses left	Full Signature of person assisting with medication

All entries must be in black ink, legible and complete. Errors must be corrected by drawing a single line through the incorrect entry. Each correction must be initialled. All changes must be co-signed.