INDIVIDUAL NARCOTIC RECORD

FAMILY NAME	FIRST	INITIAL	FACILITY Room No. Bed

Name of Drug	Rx No.	Prescribing Physician		
Directions for Usage		Route of Administration Oral ☐ Hypo ☐ Rectal ☐	Date Received	Qty Received

DATE	TIME	DOSE	O H R	NURSES SIGNATURE	AMOUNT REMAINING	VERIFIED	TIME & DATE	TIME & DATE

DISPOSITION OF UNUSED DRUG

Date of Discontinuance _____ Amount Remaining _____ Authorized Signature _____

Date and Method of Disposition _____ Authorized Signature _____

_____ Authorized Signature _____

SAMPLE