TRANSFER OF CONTROLLED SUBSTANCES FORM

FACILITY TRANSFERRING MEDICATION: From: __________________________

To: ______________________

Rx# ______________________

MEDICATION BEING TRANSFERRED: ________________________________

STRENGTH OF MEDICATION: ________________________________

NUMBER OF TABS/CAPS, ETC: ________________________________

DATE OF TRANSFER: ________________________________

SIGNATURE OF MEDICAL STAFF: ________________________________

Fax this form to the receiving facility and the pharmacy.

____________________________________________________________

FACILITY RECEIVING MEDICATION: ________________________________

ITEM RECEIVED MATCHES ABOVE ITEM SENT: YES NO

SIGNATURE OF MEDICAL STAFF ________________________________

Fax this form to the sending facility and the pharmacy.

If there is a discrepancy, complete an incident report form, notify the IHCO or HCOO and the sending facility. Send the incident report form to the pharmacy.

Received by pharmacy: ________________________________

Date Received: ________________________________

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