CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

. CENTRALLY	STORED	MEDICATION							
INSTRUCTIONS:		stored medications					Facility	Name:	
		cessible to any pers or each client/resid					Facility	Number	:
Name: (Last	Firs	st Midd	le) /	Admission Date:	Attendin	ng Physician:	Adminis	strator:	
Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date tarted	Prescribing Physician	cription ımber	No. of Refills	Name of Pharmacy

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Medication Name	Strength/ Quantity	Instructions Control/Custody	Expiration Date	Date Filled	Date Started	Prescribing Physician	Prescription Number	No. of Refills	Name of Pharmacy
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II. MEDICATION DESTRUCTION RECORD

INSTRUCTIONS: For facilities other than Residential Care Facilities for the Chronically III (RCFCI) and Residential Care Facilities for the Elderly (RCFE), prescription medication that is not taken with a client or resident when services are terminated or otherwise disposed of must be destroyed in the facility by the administrator or designated representative and witnessed by one other adult who is not a client or resident. Medication destruction records must be retained for at least one (1) year.

For **RCF-CIs:** Prescription medication that is not taken with a resident when placement is terminated or which is not to be retained must be destroyed by the administrator and the facility manager. Medication destruction records must be retained for at least three (3) years.

For **RCFEs**: Prescription medication that is not taken with a resident when services are terminated, not to be retained, not returned to the issuing pharmacy, nor retained in the facility as ordered by the resident's physician and documented in the resident's record, nor disposed of according to the hospice's established procedures, or otherwise disposed of must be destroyed in the RCFE by the administrator and one other adult who is not a resident of the RCFE. Medication destruction records must be retained for at least three (3) years.

Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

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Medication Name	Strength/ Quantity	Date Filled	Prescription Number	Disposal Date	Name of Pharmacy	Signature of Administrator or Designated Representative	Signature of Witness Adult Non-Client/Resident

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