St. Clair County Community Mental Health Authority

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: ____
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NURSE SIGNATURE: ____
NURSE PRINT: ____
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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: 7/1/2023
Policy Ref: #04-001-0050
EHR: Health Services, Other Health Documents, NOTE: Disposal of Medications