

## Controlled Substance Administration Record

Patient Name:

1. **What is the primary purpose of the study?**

Patient ID / MRN:

1. **What is the primary purpose of the study?**

Date of Birth:

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Ward / Room No.:

Medication Name:

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Strength / Dose:

Prescribing Physician:

1. **What is the primary purpose of the study?**

Start Date:

#### Notes / Additional Comments:

Reviewed By:

1. **What is the primary purpose of the study?**

Date: