

Controlled Substance Administration Record

Patient Name:

Patient ID / MRN:

Date of Birth:

Ward / Room No.:

Medication Name:

Strength / Dose:

Prescribing Physician:

Start Date:

Date	Time	Amount Administered	Route	Balance	Administered By (Signature / Name)	Verified By (Signature / Name)	Remarks

Notes / Additional Comments:

Reviewed By:

Date: