Mary Washington Healthcare EMS Medication Exchange & Narcotic Dispense Form

Used / Expired Narcotic Kit #_ Unopened Controlled Substant Etomidate Nidazolam Vecuronium Other (Medication) New Narcotic Kit # I have witnessed all waste as donarcotic kit to verify that all me as documented on the kit issue. Signature	ces Returned: (Note amount p Fentanyl Ketamine Zofran n/Amount Present: ocumented above and examine) ned the ne			
Used / Expired Narcotic Kit # _ Unopened Controlled Substant Etomidate Midazolam Vecuronium Other (Medication New Narcotic Kit # I have witnessed all waste as dinarcotic kit to verify that all medication	ces Returned: (Note amount p Fentanyl Ketamine Zofran n/Amount Present: ocumented above and examine) ned the ne			
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Used / Expired Narcotic Kit # _ Unopened Controlled Substan Etomidate	nces Returned: (Note amount p	resent)			
Used / Expired Narcotic Kit # _		resent)			
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nospital/Pharmacy Use C	only bate.				
					
Hearital/Dharman, Hear	July Date:				
Physician Signature:					
n accordance with Virginia EM	S Regulation 12VAC5-31-1140).			
Orders were received. If check					
EMS: Please check here	if Online Medical Control Me	dication			
		\dashv			
		_			
		_			
List Medications Used:	Amt. Given: Amt. Wasted	:			
Agency #					
	Full Agency Name:				
EMS Report #					
Patient Date of Birth:					
Patient Address: Patient Date of Birth:					

Mary Washington Healthcare EMS Medication Exchange & Narcotic Dispense Form

Patient Name:	
Patient Address:	
Patient Date of Birth:	
EMS Report #	
•	Name:
	EMS Unit #
List Medications Used:	Amt. Given: Amt. Wasted:
EMS: Please check here if	Online Medical Control Medication
Orders were received. If checked,	. a physician signature is required
Hospital/Pharmacy Use Or Used / Expired Narcotic Kit #	nly Date:
Unopened Controlled Substance	es Returned: (Note amount present)
Etomidate	Fentanyl
Midazolam	Ketamine
Vecuronium	Zofran
Other (Medication//	Amount Present:)
New Narcotic Kit #	<u> </u>
	cumented above and examined the new lications are present, intact, and in date :
Signature	Signature
EMS Provider Name / Title	RN / Pharmacy Name / Title