# DOCUMENTATION OF DRUG DISPOSAL

Person Receiving Service's Name: ____________________________________________________
Date: ___________________

Provider Name:_________________________________________

Name of Medication (as it appears on medication):

__________________________________________________________________________________

Type of Medication:

- ☐ Pills
- ☐ Cream
- ☐ Liquid
- ☐ Syringe
- ☐ Other__________________________

Provider Initials: _______ Count: __________
Ariel Staff Initials: ______ Count: __________

Reason for Disposal:

- ☐ Discontinued
- ☐ Change in Prescription
- ☐ Client Refusal
- ☐ Soiled
- ☐ Other: ______________________________________________________

To be completed at time of disposal:

Count confirmed:_________________

Designated Staff Signature:_________________________ Date:________________
Designated Staff Signature:_________________________ Date:________________

Revised 6/6/2018