

Arcadia Fire Department

SUBJECT: **EXPIRED/BROKEN CONTROLLED DRUG
PHARMACY REPORTING FORM**

1. Provider Agency Arcadia Fire Department Unit number
2. Request for exchange of **EXPIRED** drugs:

Drug	# of syringes or equivalent	Strength	Total
Fentanyl			mcg
Midazolam			mg
Morphine Sulfate			mg

3. Request for replacement of **BROKEN** drugs – **Broken container must accompany this request**

Drug	# of syringes or equivalent	Strength	Total
Fentanyl			mcg
Midazolam			mg
Morphine Sulfate			mg

4. Date and time narcotic was noted broken: / / @ :

5. Print name and title of individual(s) who discovered the broken narcotic:

7. Print name/title of person completing this form _____

Signature _____ Date completed: / /

8. Paramedic Coordinator's signature _____

FOR PHARMACY USE ONLY

Replaced: Fentanyl # of syringes or equivalent: Total mcg:
 Midazolam # of syringes or equivalent: Total mg:
 Morphine Sulfate # of syringes or equivalent: Total mg:

Pharmacist: _____ Date: _____ Time: _____
