VA BEACH EMS
EMERGENCY MEDICAL SERVICES

PHARMACY EXCHANGE FORM

INCIDENT #: _____ DATE: _____

_____
UNIT#

Patient Name:
DOB:

Place Pt. sticker here if available

Circle One: Transported to ED Pt. not transported

Medication Administered	Dose/Route
1.	
2.	
3.	
4.	

If additional space is needed, use reverse side of this form.

_____ _____ _____ _____
OLD NEW OLD NEW
IV BOXES DRUG BOXES

_____
WASTED NARCOTIC AMOUNT WASTED

_____
WITNESS SIGNATURE PRINTED NAME DATE

_____
ATTENDANT-IN-CHARGE SIGNATURE PRINTED NAME DATE

_____
PHYSICIAN SIGNATURE DATE

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