CSEMS/TJEMS

CONTROLLED SUBSTANCE PHARMACY EXCHANGE FORM

AFFIX PATIENT ID LABEL (IF APPLICABLE)

______/______/______ MM/DD/YYYY

________________ INCIDENT NUMBER

________________ PATIENT NAME (Last, First, MI)

________________ EMS AGENCY NAME

________________ DRUG BOX NUMBER

________________ SSN

________________ DOB

________________ CHIEF COMPLAINT

☑ MEDICATION	DOSE/AMOUNT USED	DOSE/AMOUNT WASTED	WITNESS SIGNATURE
☐ **FENTANYL**			
☐ **MORPHINE**			
☐ **VERSED**			
☐ **VALIUM**			

________________ CREW MEMBER NAME (Last, First, MI)

________________ CREW MEMBER SIGNATURE

________________ Physician Signature

CUT HERE

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