Hospital at Home Medication Box

Patient Name:_____ DOB:_____ MRN:_____

Date:_____ Print Provider Name:_____ Provider Signature:_____

This form must be returned to the pharmacy in person or via fax <u>within 72 hours</u> of medication administration
Fax # XXXXX
Use the right two shaded columns to document the amount of medication given
The Hospital at Home Medication Box <u>must remain locked</u> with a white serial lock when it is not in use
<u>Store the Hospital at Home Medication Box at room temperature</u>

Item	#	EXP Date		TECH	RPH	Amount used	Physician Initials
Syringes							
Epi Pen 0.3 mf Auto-Injector Syringe	1						
Sodium Chloride 0.9% 10 ml Syringe	6						
IV Bags							
Sodium Chloride 0.9% 1000 ml IV Bag	2						
Sodium Chloride 0.9% 500 ml IV Bag	2						
Vials							
Diphenhydramine 50 mg 1 ml Vial	2						
Furosemide 10 mg/ml 4 ml Vial	4						
Methylprednisolone 125 mg 2 ml Vial	2						
Promethazine 25 mg/ml 1 ml Vial	1						
Azithromycin 500 mg Vial Rubber banded to D5W 250 ml IVPB	1						
Ceftriaxone 1 G Vial Rubber banded to D5W 100 ml IVPB	4						
Cefepime 2 G Vial Rubber banded to D5W 100 ml IVPB	4						
Vancomycin 1 G Vial Rubber banded to D5W 250 ml IVPB	4						
Lidocaine 1% 30 ml Single Dose Vial	1						
Tablets							
Nitrostat 0.4 mg Vial (1 vial = 25 Tablets)	1						
Prednisone 10 mg Tablet	6						
Potassium Chloride 20 meq Tablet	6						
Inhalation Medications							
Ipratropium Neb Solution 0.5 mg	4						

More on back

Albuterol 0.083% Neb Solution	4						
Other							
Blank Patient Medication Labels	10						
White Serial Locks (Physician Use)	10						

Filled by:_____ Pharmacist:_____ Green Serial #:_____
Date:_____ Box #:_____ Pharmacy use only

More on back