LAC/High Desert Regional Health Center

Ambulatory Surgical Center

LOSS OF CONTROLLED DRUG REPORTING FORM

Address to: Medical Director & Pharmacy Director

1. **Date**:_____
2. **Circle Unit**: OR1 – OR2 – OR3 -- Medstation
3. **Name/Strength of Lost Control Drug:** _____
4. Total Units of Drug Lost: _____
5. Name of Nurse: _____
6. Occurrence Summary:
   _____
   _____
   _____
   _____
   _____
   _____

PLEASE DISCARD ALL MATERIAL, HAVE WITNESS SIGN.

Witness: _____ Date:_____

Signature/Category

Nurse Signature: _____ Date:_____

Signature/Category

Nurse Manager/Designee:_____ Date: _____

ASC Medical Director: _____ Date:_____

Pharmacy Director:_____ Date:_____