



Regional Controlled Substance Kit Exchange Form

Northern Virginia Emergency Medical Services Council

Initial Kit	CSK Number:	Initial Date Prepared:	Issuing Facility:	Filled By:
				<i>RPh</i>

	Medication	Amount Ordered	Amount Given	Amount Wasted*	Waste Witness Name Printed	Waste Witness Signature
Medication Inventory	1. Fentanyl 100 micrograms/2ml					
	2. Fentanyl 100 micrograms/2ml					
	3. Fentanyl 100 micrograms/2ml					
	4. Fentanyl 100 micrograms/2ml					
	5. Ketamine 500 milligrams/5ml					
	6. Ketamine 500 milligrams/5ml					
	7. Midazolam 5 milligrams/5ml					
	8. Midazolam 5 milligrams/5ml					
	9. Midazolam 5 milligrams/5ml					
	10. Midazolam 5 milligrams/5ml					
	11. Midazolam 10 milligrams/2ml					
	12. Midazolam 10 milligrams/2ml					
	13. Morphine 10 milligrams/1ml					
	14. Morphine 10 milligrams/1ml					

EMS CSK Replacement	Medications were administered: Patient Name: _____ Patient DOB: _____ Hospital MR #: _____ Incident #: _____	Reason for issue: <input type="checkbox"/> Patient care <input type="checkbox"/> Breakage* <input type="checkbox"/> Expiration* Other _____	EMS Agency: _____ Date Replaced: _____ <hr/> EMS Unit: _____	
	EMS Attendant In Charge (ALS) <i>Signature</i> <i>Printed Name (legible)</i>	EMS Co-Sign (BLS or ALS) <i>Signature</i> <i>Printed Name (legible)</i>		
Hospital	Accepting MD, PA-C or NP <i>Signature</i> <i>Printed Name (legible)</i>	CSK returned, received and verified by: <i>RPh/RN Signature</i> <i>Printed Name (legible)</i>		Date: _____

*Excess medication shall NOT be wasted at the pharmacy.

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For more information contact Northern Virginia EMS Council
877-261-3550 northern@vaems.org

Attach patient sticker here (if available)