AHN Facility

____ Allegheny General
____ Allegheny Valley
____ Canonsburg
____ Forbes
____ Jefferson
____ St. Vincent
____ West Penn

Allegheny Health Network
Prehospital Care Services

Controlled Substance Replacement Form

ALS Service: _____

Completed By: _____

Certification #: _____

Date: _____ / _____ / _____

Cost Center #: _____

Cost Center Name #: _____

Signature of person receiving Medications:

_____

Choose *only* one per form:

Medication		Unit of Measure	Dosage	Ex-change (count)	Replace (count)	New (count)
Diazepam	*Valium*	Carpuject	10 mg / 2 ml			
Fentanyl	*Sublimaze*	Carpuject	100 mcg / 2 ml			
Ketamine	*Ketalar*	Vial	500 mg / 5 ml			
Morphine Sulfate		Carpuject	10 mg / 1 ml			
Midazolam	*Versed*	Vial	5 mg / 1 ml			

Patient information:

Check one: ☐ **Protocol** ☐ **MD Order**

Name:_____ Trip Sheet # :_____

Date of Birth: _____ / _____ / _____ Dose Administered:_____

Dose Administered: _____

Date Administered: _____ Time Administered: _____

Paramedic Administering: _____ State Certification # _____
(Signature)

Medic Command Physician ORDERING Medication: _____
(Name)

Medic Command Physician ORDERING Medication: _____
(DOH Number)

Person Witnessing Disposal of Unused Drug: _____
(Signature)

Pharmacy information:

Pharmacist/RN Issuing Replacement: _____
(Signature)

Paramedic Receiving Replacement: _____
(Signature)

Date of Replacement: _____

****PCR required to be delivered to Prehospital Coordinator within 24 hours****

Physician: _____
(Signature Required)

DEA Number: _____