Date: _____

Discharge Medication Routing Form (Tube #46)

Patient Name: _____ Unit: _____ Room #: _____

Patient DOB: _____ Pharmacist Name & Ext: _____

☐ Delivery ☐ Pick-up

Expected Discharge/Delivery Time: _____

☐ Counseling completed by the **PHARMACIST**.

☐ Counseling will be completed upon delivery of medications.

☐ Counseling will be provided by the nurse and pt **MUST** pick up in the pharmacy

Notes:

Time Received: _____

Date: _____

Discharge Medication Routing Form (Tube #46)

Patient Name: _____ Unit: _____ Room #: _____

Patient DOB: _____ Pharmacist Name & Ext: _____

☐ Delivery ☐ Pick-up

Expected Discharge/Delivery Time: _____

☐ Counseling completed by the **PHARMACIST**.

☐ Counseling will be completed upon delivery of medications.

☐ Counseling will be provided by the nurse and pt **MUST** pick up in the pharmacy

Notes:

Time Received: _____