

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: \_\_\_\_\_

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