

## ASPIRANET RESOURCE FAMILY PROGRAM MONTHLY MEDICATION RECORD

Name:			Attending Physician:									Month:				Year:	
Medication:			D ( E'' )					Pharmacy:				Approval Method					
Strength/Quantity:			Date Filled:					RX#:				☐ □ Approval on OTC Formulary (RF-45)					
Instructions:			Date Started:					No. of Refills:				□ Verbal approval by Auth'zd Med. Prof'snl (on RF-06)					
Control/Custody:			Expiration Date:			Physician:					☐ Prescription by Authorized Medical Professional						
Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
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Day	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	DISPOSAL	
Time																Disposal Date:	
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Time							İ		Ì							Sig of Admin:	
Initials																1	
Time																	
Initials																Sig of Witness	
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Medication	1:							Pharmacy:			Ap	proval Metho	od				
Strength/ Quantity:			Date Filled:					RX#:				☐ Approval on OTC Formulary (RF-45)					
Instructions:			Date Started:					No. of Refills:				☐ Verbal approval by Auth'zd Med. Prof'snl (on RF-06)					
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Initials																2.5 0.7.3	
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Initials																Sig of Witness	
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