



# E-KIT USAGE NOTIFICATION

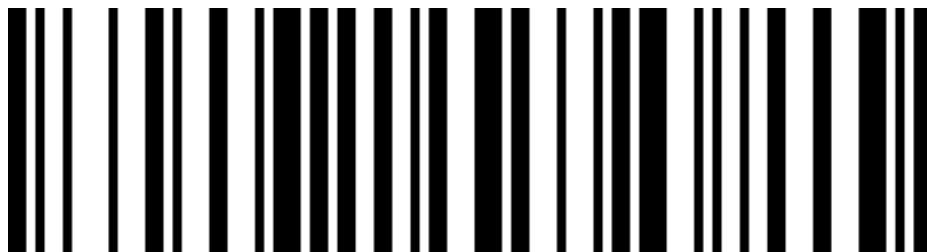
Facility \_\_\_\_\_ Wing \_\_\_\_\_

Patient \_\_\_\_\_ Date \_\_\_\_\_

Physician \_\_\_\_\_ Time \_\_\_\_\_ AM / PM

Medication	Strength	Serial #	Directions	Qty Used/ Remaining
				/
				/
				/
				/
				/
				/
				/

Nurse's Signature \_\_\_\_\_



ER KIT

PLEASE FAX COMPLETED FORM TO THE PHARMACY EVERY TIME A MEDICATION IS REMOVED FROM THE ER KIT.