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.