

## **Medication Transfer Sheet/Release of Responsibility**

Name of Facility: \_\_\_\_\_

Name of Resident: \_\_\_\_\_

Date of Release: \_\_\_\_\_ Expected Date of Return: \_\_\_\_\_

Name of Medication	Pass Time	RX Number	Strength	# of Meds Released	# of Meds Returned

When transferring medications for home visits, outings, etc., the facility may:

- a. Give the full prescription contained to the resident, or responsible person/authorized representative.

OR

- b. Have the pharmacy fill a separate prescription or separate the existing prescription into two bottles.

OR

- c. Have the consumer's/resident's family obtain a separate supply of the medication for use when the consumer/resident visits with the family.

The resident, and/or responsible party assumes responsibility for the resident and for assuring that all medication (if any) are taken appropriately, during the time the resident is signed out of the facility. The facility is not responsible for any accidents, illnesses or injury during this time. My signature indicates that I have received the above listed medications, and have been instructed in their use. I also agree to return any unused medications when the visit is concluded.

Signature of staff releasing medications: \_\_\_\_\_

Received by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Signature of person returning unused medications: \_\_\_\_\_

Staff signature of count on return: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_