

Controlled Drugs Transfer Form

PLEASE COMPLETE 2 COPIES OF THIS FORM – 1 TO BE KEPT IN SUPPLYING WARD / DEPARTMENT AND OTHER TO BE KEPT IN RECEIVING WARD / DEPARTMENT

Ward / Hospital / Department: _____ Date: _____

Date / Time	Medicine (including form and strength)	Quantity	Transferred From (Location) (Envopak No.)	Supplied To (Location)	Supplied by (Print Name and Job Role)	Supplied by (Signature)	Received by (Print Name and Job Role)	Received by (Signature)

Checked by Senior Charge Nurse:		Location:		Date:	
Checked by Pharmacist/ Pharmacy Technician		Location:		Date:	