



Regional Controlled Substance Kit Exchange Form

Northern Virginia Emergency Medical Services Council



Effective 11/2020

Initial	CSK Number:	Date Issued:	Issuing Facility:	Filled By:
				RPh:

	Medication	Amount Ordered	Amount Given	Amount Wasted	Waste Witness Printed Name	Waste Witness Signature
Medication Inventory	1. Fentanyl 100 micrograms/2ml					
	2. Fentanyl 100 micrograms/2ml					
	3. Ketamine 500 milligrams/5ml					
	4. Midazolam 5 milligrams/5ml					
	5. Midazolam 5 milligrams/5ml					
	6. Midazolam 10 milligrams/2ml					
	7. Midazolam 10 milligrams/2ml					
	8. Morphine 10 milligrams/1ml					

EMS CSK Replacement	Medications were Administered: Name of Provider Administering: (print) _____ Administering Provider's Unit #: _____ Medications Administered To: Patient Name: _____ Patient DOB : _____ Hospital MR#: _____ Incident#: _____	Reason for Replacement: <i>(Excess medication and empty vials should not be taken to the pharmacy for replacement/disposal)</i> <input type="checkbox"/> Patient care <input type="checkbox"/> Breakage <input type="checkbox"/> Expiration <input type="checkbox"/> Other _____	Date Replaced: _____ EMS Unit #: _____ EMS Agency: _____
	EMS Attendant in Charge (ALS): <i>Signature</i> _____ Printed Name (legible) _____		Receiving Hospital Name: _____ EMS Co-Sign (BLS or ALS): <i>Signature</i> _____ Printed Name (legible) _____

Hospital	Accepting MD, PA-C or NP Signature _____ Printed Name (legible) _____	CSK Returned, Received and Verified By: <i>RPh/RN/CPhT Signature</i> _____ Printed Name (legible) _____	Date: _____
-----------------	--	---	-----------------------

For more information contact Northern Virginia EMS Council at (877) 261-3550 or northern@vaems.org