OKLAHOMA DEPARTMENT OF CORRECTIONS

COMMUNITY CORRECTIONS
(select appropriate box)

☐ **SUPERVISED MEDICATION/SYRINGE COUNT LOG**

☐ **SUPERVISED TDU MEDICATION LOG**

Inmate Name: _____ DOC #: _____

Medication/Syringe: _____Quantity: _____ RX #: _____

Instructions: _____

Medication/Syringes Delivered By: _____ Date: _____

Date	Time	Med Quantity		Syringe Quantity		Inmate Signature	Staff Signature	Bal	Count Correct Time/Date
		(+)	(-)	(+)	(-)				Nurse Signature

*For any unresolved discrepancies, please notify the facility shift supervisor and CHSA (host facility) within one hour of discovery. See MSRM 140130-03 entitled “Controlled Drug Procedures” for further instruction.