AVEL PHARMACY eCare

PHARMACIST VERIFICATION OF PATIENT'S OWN MEDICATIONS

Patient Sticker Here

Facility name : _____

Patient name from bottle(s): _____

Medication Name from bottle	Strength	Dosage form (tab/cap/etc)	Color	Shape	Imprint on Side 1	Imprint on Side 2	**Pharmacist Use Only** Medication Verified as:

Home Medications: May use patient's medication (s)-keep in medication room or order use of home medications through CPOE

_____ _____

Practitioner Signature Date