Pharmacist Verification of Patient's Own Medications

Facility Name: _____

Patient name from bottle(s): _____

Patient Sticker Here

Please complete this form and send to the Avel Pharmacy Routine Fax Line: 866-371-7310

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