Procedure for the Control of Controlled Substances
In First Nations and Inuit Health Branch managed health facilities

ANNEX 1
CONTROLLED SUBSTANCES SIGNATURE AND ACKNOWLEDGEMENT FORM

Name of Health Facility _____ **Page #** _____

It is mandatory to complete Annex 1 for ALL employees who have been granted access to Controlled Substances by the nurse in charge and who will make entries in the Control Substances Register Forms. Your signature is required for identification purposes and to indicate you have read and understood the FNIHB Policy and Procedures on the Control of Controlled Substances. This form must be signed before making any entries in other Controlled Substances Register Forms.

Date (YY-MM-DD)	Name (Please Print)	Qualification Or Position	Signature	Initials

Keep sheet for two (2) years after last entry. Personnel must re-sign upon each assignment or return from leave. Blank forms to be reproduced locally.

First Nations and Inuit Health Branch – Procedure for the Control of Controlled Substances

ANNEX 2A
CONTROLLED SUBSTANCES REGISTER FORM – DRUG COUNT – SINGLE DRUG

Page # _____

Name of Health Facility:			Drug Name (Generic) & Strength:				Unit of issue:
DATE	TIME	PATIENT NAME	Quantity			Practitioner Physician/	Nurse's
(YY-MM-DD)		(or Supplier's Name)	Rec'd	Issued	Bal.	Nurse	Signature

Note:

- Drug Counts and Drug Received in **RED** ink
- Issued (Quantity of drug dispensed, returned or destroyed) in **BLACK** ink
- Errors: Strike out and initial

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ANNEX 2B
CONTROLLED SUBSTANCES REGISTER FORM – DRUG COUNT – COMBINED FORM

Name of Health Facility: _____ # Drug counts and additions (receipts) in **RED** ink # Issues (Dispensed, returned or destroyed) in **BLACK** ink Errors – strike out and initial				Units issued/received by tabs, amp or ml (for syrup only)	Codeine 30 mg tabs min 10 – max 25	Codeine syrup 5 mg/ml min 20 – max 100 mL	Meperidine (Demerol) 50 mg tabs min 10 – max 25 tabs	Meperidine (Demerol) 50 mg/mL min 5 – max 25	Morphine 10 mg/mL amps min 2 – max 10	Morphine syrup 5 mg/mL supply on demand	Phenobarbital 120 mg/mL amps min 10 – max 20			Page # _____	
			Forwarded Balance →											Prescriber's name	Nurse's signature
Date (yy-mm-dd)	**Time 24 hr. clock**	**Full First & Last Name Band # & DOB**	**Drug Name/Strength Unit of Issue**	**Quantity**											

First Nations and Inuit Health Branch – Procedure for the Control of Controlled Substances
ANNEX 2B
CONTROLLED SUBSTANCES REGISTER FORM – DRUG COUNT – COMBINED FORM

EXAMPLE

Name of Health Facility:

Little Beaver NS

Drug counts and additions (receipts) in **RED** ink
Issues (Dispensed, returned or destroyed) in **BLACK** ink
Errors – strike out and initial

Page # 14

				Units Issued/received by tabs, amp or ml (for syrup only)	Codeine 30 mg tabs min 10 – max 25	Codeine syrup 5 mg/ml min 20 – max 100 mL	Meperidine (Demerol) 50 mg tabs min 10 – max 25 tabs	Meperidine (Demerol) 50 mg/mL min 5 – max 25	Morphine 10 mg/mL amps min 2 – max 10	Morphine syrup 5 mg/mL supply on demand	Phenobarbital 120 mg/mL amps min 10 – max 20				
			Forwarded Balance →		25	50 mL	10	20	8	32 mL	20			Prescriber's name	Nurse's signature
Date (yy-mm-dd)	**Time**	**Full First & Last Name Band #, & DOB**	**Drug Name/Strength/ Unit of Issue**	**Quantity**											
04-06-04	4:44 pm	Barbara. Hurt, 67 LB, 20/12/61	Demerol 50 mg tabs I tab q6h PRN for pain	4			6							Dr. Doright	J. Pond RN sign
04-06-04	4:59 pm	Drug Count			25	50	6	20	8	32	20			J. Pond RN sign	B. Hill RN sign
04-06-05	4:30 pm	Drug Count			25	50	6	20	8	32	20			J. Pond RN sign	B. Hill RN sign
04-06-06	7:30 am	Matthew. Etoo, 57 LB, 21/08/80	Meperidine 50 mg, 75mg IM	1.5				18.5						J. Pond, RN	J. Pond RN sign
04-06-06	1:00 pm	Wasted	Meperidine 50 mg, 25 mg IM	0.5				18						B. Hill, RN	J. Pond RN sign
04-06-06	1:24 pm	MHC Pharmacy	Demerol 50 mg tabs	10			16							B. Hill, RN	J. Pond RN sign
04-06-06	4:30 pm	Ette. Knownow, 2 LB, 25/9/55	Morphine 10 mg IM stat	1					7					B. Hill RN	B. Hill RN sign
04-06-06	4:40 pm	Drug Count			25	50	16	18	7	32	20			J. Pond RN sign	B. Hill RN sign
04-06-07	10:35 am	Robert. Happy, 134 LB, 08/05/97	Codeine syrup 2 ml stat	2		48								Dr. Visiting	J. Pond RN sign

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ANNEX 3
CONTROLLED SUBSTANCES MONTH END REPORT (Please submit first week following month end)

Name of Facility _____ Month _____ Year _____

Count-Controlled Drugs	Balance End Last Month	Stock Received	Stock Used	Stock Disposed Of	Balance This Month End
CODEINE 30 mg tablets					
CODEINE SYRUP 5 mg/mL					
MEPERIDINE 20 mg tablets					
MEPERIDINE 50 mg/mL ampules					
MORPHINE 10 mg/mL ampules					
MORPHINE SYRUP 5 mg/mL					
PHENOBARBITAL 120 mg/mL ampules					
TYLENOL No. 2 (15 mg) tablets					
TYLENOL No. 3 (30 mg) tablets					
ATASOL No. 2 (15 mg) tablets					
ATASOL No. 3 (30 mg) tablets					
DIAZEPAM 5 mg tablets					
DIAZEPAM 5 mg/mL ampules					
LORAZEPAM 1 mg tablets					
LORAZEPAM 4mg/mL ampules					
OXAZEPAM 15 mg tablets					

Month End Report Completed By: _____ Nurse in Charge	Date: (YY-MM-DD) _____
Approved By: _____ Zone Nursing Officer	Date: (YY-MM-DD) _____
Reviewed By: _____ Regional Controlled Substances Officer	Date: (YY-MM-DD) _____

DISTRIBUTION: Health Facility (keep photocopy for Controlled Substances Register)
Assistant Zone Nursing Officer
Pharmacist, SLMHC

EXAMPLE

First Nations and Inuit Health Branch – Procedure for the Control of Controlled Substances

ANNEX 3
CONTROLLED SUBSTANCES MONTH END REPORT (Please submit first week following month end)

Name of Facility _____ Month _____ Year _____

Count-Controlled Drugs	Balance End Last Month	Stock Received	Stock Used	Stock Disposed Of	Balance This Month End
CODEINE 30 mg tablets	25	-	-	-	25
CODEINE SYRUP 5 mg/mL	50 mL	-	2	-	18 mL
MEPERIDINE 20 mg tablets	10	10	4	-	16
MEPERIDINE 50 mg/mL ampules	20	-	2	-	18
MORPHINE 10 mg/mL ampules	8	-	1	-	7
MORPHINE SYRUP 5 mg/mL	32 mL	-	-	-	32 mL
PHENOBARBITAL 120 mg/mL ampules	20	-	-	-	20
TYLENOL No. 2 (15 mg) tablets	200	-	-	-	200
TYLENOL No. 3 (30 mg) tablets	164	60	15	-	209
ATASOL No. 2 (15 mg) tablets	50	-	-	-	50
ATASOL No. 3 (30 mg) tablets	44	-	-	-	44
DIAZEPAM 5 mg tablets	35	-	-	-	35
DIAZEPAM 5 mg/mL ampules	10	-	1	-	9
LORAZEPAM 1 mg tablets	45	-	12	-	33
LORAZEPAM 4mg/mL ampules	10	-	1	-	9
OXAZEPAM 15 mg tablets	20	-	-	-	20

Month End Report Completed By: _____ Nurse in Charge	Date: (YY-MM-DD) _____
Approved By: _____ Zone Nursing Officer	Date: (YY-MM-DD) _____
Reviewed By: _____ Regional Controlled Substances Officer	Date: (YY-MM-DD) _____

DISTRIBUTION: Health Facility (keep photocopy for Controlled Substances Register)
Assistant Zone Nursing Officer
Pharmacist, SLMHC

ANNEX 4
REQUEST FOR DESTRUCTION (Please check one box only)

NARCOTICS AND/OR CONTROLLED DRUGS ☐

BENZODIAZEPHINES ☐ Note: Please list benzodiazepines on a separate sheet from narcotics and controlled drugs

to: REGIONAL OFFICE
(Regional office address)
First Nations and Inuit Health Branch
Health Canada

ATTENTION: Regional Director/Regional Controlled Substances Officer

FROM: NAME OF HEALTH FACILITY: _____

SUBJECT: This request is to obtain permission for destruction of the following controlled substances:

Name of Drug	Unit of Issue	Strength	Quantity	Expiry Date (YY-MM-DD)	Reason

Signature & Date (Nurse in Charge) _____

Signature & Date (ZNO / AZNO) _____

Signature & Date (Regional Controlled Substances Officer) _____

NOTE: The Regional Controlled Substances Officer may only approve requests for destruction of benzodiazepines. The Regional Controlled Substances Officer must review and forward requests for destruction of narcotics and controlled drugs to the Office of Controlled Substances (Health Canada) for approval.

AFTER PERMISSION RECEIVED TO DESTROY THE ABOVE MENTIONED DRUGS (ATTACH AUTHORIZATION LETTER FROM OFFICE OF CONTROLLED SUBSTANCES OR FROM REGIONAL OFFICE AS APPLICABLE):

Certify having witnessed the destruction of above listed medication(s). The medication(s) destroyed has/have been altered or denatured to such an extent that their consumption has been rendered impossible or improbable.

DATE DESTROYED _____(or returned to _____ for destruction/attach receipt from authorized contractor)

BY: NURSE IN CHARGE (Print): _____ Signature _____

WITNESS (Print): _____ Signature _____

NOTE: After destruction, please keep this document and the authorization letter(s) in the controlled substances register (and the receipt voucher from an authorized contractor as applicable.)

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ANNEX 5
CONTROLLED SUBSTANCES VERIFICATION TOOL

Page # _____

VERIFICATION DONE BY : _____

NAME OF FACILITY: _____ DATE: _____

CONTROLLED SUBSTANCE REGISTER FORMS					CLIENT'S FILES								
Date YY-MM-DD	Drug	Route	Dose	Remarks	Date YY-MM-DD	Time	Drug	Route	Dose	Diagnosis	Consul-tation	Follow-up	Remarks

First Nations and Inuit Health Branch – Procedure for the Control of Controlled Substances

ANNEX 2B
CONTROLLED SUBSTANCES REGISTER FORM – DRUG COUNT – COMBINED FORM

Name of Health Facility:

_____

Drug counts and additions (receipts) in **RED** ink
Issues (Dispensed, returned or destroyed) in **BLACK** ink
Errors – strike out and initial

Page # _____

						Amount wasted by mg, tab, or mL for syrup only	Units removed by tabs, amp, or mL for syrup only	Codeine 30 mg tabs "B" min 10 – max 25	Codeine syrup 5 mg/ml "D" min 20 – max 100 mL	Meperidine (Demerol) 50 mg tabs "B" min 10 – max 25 tabs	Meperidine (Demerol) Inj 50 mg/mL "D" min 5 – max 25	Morphine 10 mg/mL amps "D" min 2 – max 10	Morphine syrup 5 mg/mL "B" supply on demand	Phenobarbital 120 mg/mL amps "B" min 10min – max 20	Acetaminophen & Codeine 15 mg tabs "C min 40 – max 200	Acetaminophen & Codeine 20 mg tabs "C" min 40 – max 200	Diazepam (Valium) 5 mg Tabs "D" min 10 – max 50	Diazepam 5 mg/mL 2mL amp "D" min 10 – max 10	Lorazepam (Ativan) 1 mg Tabs "D" min 10 – max 50	Lorazepam (Ativan) mg/mL amp (Fridge) "0" min 5 – max 10	Oxazepam (Serax) 15 mg Tabs "B" min 10 – max 25	Midazolam (versed) 5 mg/mL 2 mL amp "B" min 1 – max 5		
			Forwarded Balance →																				Prescriber's Name	Nurse's Signature
Date yy-mm-dd	**Time**	**Patient, Band #**	**Drug/Dose/Route**	**#**	**#**																			