United Support Services, Inc.

"The works of many coming together for the good of One"

Control Drug Count Sheet

Member's Name: ______________________ Member's Medicaid #: ______________________

Medication Name: ______________________ Month/Year: ______________________

Date of last refill: ______________________ Quantity filled: ______________________

Date of refill (in current month): ______________________ Quantity filled: ______________________

Date	Beginning Count	Time	# Pills Given	Dose Given By (Name):	Ending Count	Count Verified By (Signature):