

MONTHLY MEDICATION LOG

Use this form to document your use of controlled substances & return it to HPSP after ending the prescription or at end of the month.

PLEASE PRINT

Participant Name:	DOB:	Prescriber:
Reporting Month/Year:	Is the prescriber your primary care provider? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Medication/mg:	If no to above, is your primary care provider aware of rx? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dosing Instructions:	Pharmacy Name:	

Copy RX on file? Yes No Provide HPSP with copies of prescriptions for all controlled substances, including refills, within 3 days of filling.

Date	Time	#Taken	#Remain	Date	Time	#Taken	#Remain	Date	Time	#Taken	#Remain
1 st				12 th				23 rd			
2 nd				13 th				24 th			
3 rd				14 th				25 th			
4 th				15 th				26 th			
5 th				16 th				27 th			
6 th				17 th				28 th			
7 th				18 th				29 th			
8 th				19 th				30 th			
9 th				20 th				31 st			
10 th				21 st							
11 th				22 nd							

- Use one form for each controlled substance.
- Ensure appropriate disposal of unused controlled substances.

Additional form available at mn.gov/boards/hpsp/