**STATE OF ALASKA** **DEPARTMENT OF CORRECTIONS**

# TRANSFER OF CONTROLLED SUBSTANCES FORM

**FACILITY TRANSFERRING MEDICATION:** From: ______________________

To: ______________________

Rx# ______________________

MEDICATION BEING TRANSFERRED: ______________________

STRENGTH OF MEDICATION: ______________________

NUMBER OF TABS/CAPS, ETC: ______________________

DATE OF TRANSFER: ______________________

SIGNATURE OF MEDICAL STAFF: ______________________

Fax this form to the receiving facility and the pharmacy.

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**FACILITY RECEIVING MEDICATION:** ______________________

ITEM RECEIVED MATCHES ABOVE ITEM SENT: YES NO

SIGNATURE OF MEDICAL STAFF ______________________

Fax this form to the sending facility and the pharmacy.

If there is a discrepancy, complete an incident report form, notify the IHCO or HCOO and the sending facility. Send the incident report form to the pharmacy.

Received by pharmacy: ______________________

Date Received: ______________________