ORAL SYRINGE MEDICATION QA WORKSHEET

Date:_____ **Total:**_____

REMINDER – Log Refrigerator/Freezer Temperatures **Shift: 7-3** **Shift: 3-1** **Shift: 9-6**

Quality Control Procedures:
Each of the following must be performed and indicated on the label by checks (√) then signed by a Pharmacist

☐ Medication is correct and matches bag/bottle used ☐ Dosage form is correct (tab/cap/suspension/syrup) ☐ Calculation of dose must be verified
☐ Date and initials of person preparing med is correct ☐ Manufacturer/Cmpd/brand name is correct ☐ Lot number is correct and matches bottle
☐ Expiration date is correct according to policy ☐ Number of meds prepared has been verified ☐ NDC # (if available) is correct
☐ Volume of liquid in syringes/vials as noted on label or number of tabs/caps packaged to deliver dose is correct

STAFF IDENTIFICATION: PLEASE <u>PRINT</u>

Initials	Name	Initials	Name

MEDICATION PREPARATION AND REVIEW

Qty	LABEL	Tech/ RPh	Qty	LABEL	Tech/ RPh

Qty	LABEL	Tech/ RPh	Qty	LABEL	Tech/ RPh