____ COUNTY CORONER'S/MEDICAL EXAMINER'S OFFICE MEDICATION INVENTORY

NAME OF DECEDENT _____ DATE OF DEATH _____ CASE #_____

PRESCRIPTION (Name of medication and mg dosage strength)	PRESCIPTION NUMBER (Assigned by pharmacy)	PRESCRIBING PHYSICIAN	DATE PRESCRIPTION FILLED	PHARMACY	DOSAGE & FREQUENCY (i.e., 1 capsule /day)	CONDITION FOR WHICH PRESCRIBED (Use/Indications)	QUANTITY PRESCRIBED	QUANTITY REMAINING

NAME AND TITLE OF PERSON REMOVING MEDICATIONS	DATE REMOVED	WITNESS NAME AND TITLE (If applicable)	WITNESS SIGNATURE

MEDICATIONS REMOVED FROM (Check all appropriate boxes.)
❒ DECEDENT'S BODY ❒ DECEDENT'S HOME ❒ HOSPITAL/NURSING HOME/CBRF/HOSPICE CENTER ❒ OTHER PLACE (Specify):

NAME AND TITLE OF PERSON DISPOSING OF MEDICATIONS	DATE OF DISPOSAL	WITNESS NAME AND TITLE (If applicable)	WITNESS SIGNATURE

METHOD OF DISPOSITION

UNOPENED MEDICATIONS FORWARDED TO THE STATE PHARMACEUTICAL REPOSITORY? ❒ NO ❒ YES (If yes, list medications forwarded)

1.	DATE FORWARDED	NAME OF PHARMACY/PERSON RECEIVING MEDICATIONS
2.		SIGNATURE OF PHARMACIST/PERSON RECEIVING MEDICATIONS