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| --- |
| **Section I: To be completed by the facility using the product.** |
| **Location:**       |
| **Product** | **Strength (IU or mg)** | **Lot Number** | **Expiration Date** | **Number of Vials****Dispensed** | **Dispensed** | **Dispensed by**(Hospital Staff Initials) | **Comments** |
| **Date** | **Time** |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
|       |       |       |       |       |       |       |       |       |
| Comments:      |
| **Section II: To be completed by the facility using the product** |
| Faxed to Versiti by: | Date: | Time: |

Versiti Staff: Attach this form to the corresponding Pick Sheet.