San Bernardino County
Department of Behavioral Health

CLIENT ORAL MEDICATION LOG

Date Received	Medication Name	Dosage	Quantity	Quantity Given	New Count	Date/Time Given	Staff Initials	Client/Authorized Representative Signature

***Please document in the chart on the Outpatient Medication Record the date, quantity, and route of administration, or if returned to the pharmacy in the case of medication discontinuance, patient's refusal or case closed, etc.**

DOCTOR: _____ **NURSE:** _____

San Bernardino County
DEPARTMENT OF BEHAVIORAL HEALTH
Confidential Patient Information

NAME:
DOB:
CHART NO:
PROGRAM: