CRMC CHECKLIST FOR THE ACCEPTANCE OF INJECTABLE SUBSTANCES INTO THE CLINIC FROM ALLERGOLOGIST OFFICE AFTER FIRST USE BY ALLERGOLOGIST FOR MEDICAL GRADE REFRIGERATION STORAGE

Who can accept injectable medications at CRMC: Only Physicians, Nurse Practitioners, Registered Nurses, Licensed Practical Nurses, and Registered Health Care Aides with specific training for this procedure.
This checklist must be stapled to the prescription paper contained in the package.

What to look for before accepting an injectable medication into the clinic:

☐ Is the medication to be administered via IV route?
If it is, **REFUSE ACCEPTANCE**

☐ Was the medication issued by an allergologist or RN/CNS within the past 1 hour?
If the medication did not come directly from an allergologist's office, ***REFUSE ACCEPTANCE***
If the medication took more than 1 hour to arrive from the allergologist's office to the clinic, ***REFUSE ACCEPTANCE***

☐ Was the medication transported in a thermal bag without ice?
If the medication was transported with ice, ***REFUSE ACCEPTANCE***
If the medication or package was not contained in a thermal bag, ***REFUCE ACCEPTANCE***

☐ Does the medication or its packaging feel warm to touch?
If the medication vial feels warm to touch, ***REFUSE ACCEPTANCE***

☐ Does the medication look discoloured or in a non-uniform state (i.e. partially solid and partially liquid)
If it does, ***REFUSE ACCEPTANCE***

☐ Was the Declaration of First Use filled correctly by the allergologist or RN/CNS in all its sections?
If not, ***REFUSE ACCEPTANCE***

☐ Is the medication/substance in date?
If the medication has passed the expiry date, ***REFUSE ACCEPTANCE***

☐ Is there a printed prescription with posology contained in the package?
If there is no prescription with posology contained it in, ***REFUSE ACCEPTANCE***

NAME OF STAFF MEMBER WHO COMPLETED THE CHECKLIST AND DATE

_____

DESIGNATION OF MEMBER OF STAFF WHO COMPLETED THE CHECKLIST

MD	NP	RN	LPN	HCA with specific training
☐	☐	☐	☐	☐

DECLARATION OF FIRST DOSE USE BY ALLERGOLOGIST OR RN/CNS

Date: ___/___/_____

I declare that the vial #_____ with expiry date ___/___/_____, which I used to administer the first dose to Mr./Mrs./Ms. (circle the appropriate one) _____ (write full name of patient) on ___/___/_____, was sealed before I used it on such date.

☐ I AM A REGISTERED NURSE OR CNS

OR

☐ I AM A PHYSICIAN

PRINT FULL MANE: _____

SIGNATURE: _____

CPSA or CRNA #: _____

STAMP OF THE PROVIDER