PharMerica®
Senior Living

# CYCLE DOSE REPLACEMENT FORM

**DATE:** _____

**COMMUNITY NAME:** _____ **STAFF NAME:** _____

RESIDENT NAME: _____ RESIDENT NAME: _____

MEDICATION: _____ MEDICATION: _____

DIRECTIONS: _____ DIRECTIONS: _____

HOW MANY DOSES NEEDED UNTIL NEXT EXCHANGE: _____ HOW MANY DOSES NEEDED UNTIL NEXT EXCHANGE:_____

REASON WHY NEED EXTRA DOSE: REASON WHY NEED EXTRA DOSE:

_____ Resident Refused _____ Resident Refused

_____ Resident Spit Out _____ Resident Spit Out

_____ Dose Was Dropped _____ Dose Was Dropped

_____ Other _____ Other

---

RESIDENT NAME: _____ RESIDENT NAME: _____

MEDICATION: _____ MEDICATION: _____

DIRECTIONS: _____ DIRECTIONS: _____

HOW MANY DOSES NEEDED UNTIL NEXT EXCHANGE: _____ HOW MANY DOSES NEEDED UNTIL NEXT EXCHANGE:_____

REASON WHY NEED EXTRA DOSE: REASON WHY NEED EXTRA DOSE:

_____ Resident Refused _____ Resident Refused

_____ Resident Spit Out _____ Resident Spit Out

_____ Dose Was Dropped _____ Dose Was Dropped

_____ Other _____ Other

---

RESIDENT NAME: _____ RESIDENT NAME: _____

MEDICATION: _____ MEDICATION: _____

DIRECTIONS: _____ DIRECTIONS: _____

HOW MANY DOSES NEEDED UNTIL NEXT EXCHANGE: _____ HOW MANY DOSES NEEDED UNTIL NEXT EXCHANGE:_____

REASON WHY NEED EXTRA DOSE: REASON WHY NEED EXTRA DOSE:

_____ Resident Refused _____ Resident Refused

_____ Resident Spit Out _____ Resident Spit Out

_____ Dose Was Dropped _____ Dose Was Dropped

_____ Other _____ Other

***Based on the information noted above, we will submit a bill for dropped or spit out medication to the third payer. If rejected, it will revert to a facility charge.***