East Central Illinois EMS

Basic Life Support (BLS) Agency
Expired/Replacement Medication Request Form

Date: _____ Agency Name: _____ Unit #: _____

Contact Person: _____ Contact Number: _____

EMS Fax: 217-359-7408 **EMS Phone Number: 217-359-6619**

Par Level (each unit)	Medication	Quantity Needed	Quantity Given by Pharmacy
2	Acetaminophen, 500 mg		
4	Aspirin, 81mg chewable tablet		
1	Diphenhydramine, 50 mg tablet		
2	DuoNeb (Albuterol and Ipratropium) 3ml		
1	Epinephrine 1:1000 1mg/1ml**, vial only**		
2	Naloxone (Narcan) 2mg/2ml syringe		
1 bottle	Nitroglycerin 0.4 mg, spray or tablet		
2	Oral Glucose 15g tube		
1	Zofran ODT 4mg		

EMS Office Approval: (EMS Coord. or EMSED Signature)	Date / Time:
Request filled by: (HMMC or SHMC Pharmacy Signature)	Date / Time:
Request Picked up by: (EMS Provider Signature)	Date / Time:

Bring expired medications with when picking up medications

Bill to:

Agency Name: _____

Agency Address: _____

City: _____ State/Zip code: _____

Primary Contact Name: _____

Phone: _____