East Central Illinois EMS

Expired/Replacement Medication Request Form – Transport ILS/ALS

Date: _____ Agency Name: _____ Unit #: _____

Contact Person: _____ Contact Number: _____

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

Bring expired medications with when picking up new medications

Par Level	Medication	Quantity Needed	Quantity Given by Pharmacy
MAXIMUM	**Controlled Substances**		
4	Fentanyl 100mcg/2ml		
2	Morphine 2mg/ml syringe		
2	Morphine 10mg/ml syringe		
4	Midazolam 5mg/5ml vial		
1	Midazolam 10mg/2ml syringe **(For IN use Only)**		
MINIMUM	**Medications**		
3	Acetaminophen (Tylenol) 325mg tablets		
5	Adenocard (Adenosine) 6mg/2ml		
3	Amiodarone 150mg/3ml		
4	Aspirin, 81mg chewable tablets		
2	Atropine 1mg/10ml pre-filled syringe		
1	Atropine 0.4 mg/ml, 20ml vial (One patient use)		
1	Benzocaine spray		
2	Cardizem, 100mg Add-vantage vial with 100ml NS Diluent		
2	Dextrose 50% (D50) 25g/50ml pre-filled syringe **-OR-** Dextrose 10% (D10) 25g/250ml		
1	Diphenhydramine (Benadryl) 50mg/ml		
1	Dopamine 400mg/250ml D5W		
4	DuoNeb (Albutrol and Ipratropium) 3ml		
2	Epinephrine 1:1000 1mg/ml ampule		
6	Epinephrine 1:10,000 1mg/10ml pre-filled syringe		
2	Glucagon 1mg/1unit		
2	Oral Glucose 15g Tube		
3	Lidocaine 2% 100mg/5ml syringe		
1	Lidocaine 2g/500ml D5W **-OR-** 1g/250ml D5W		
4	Magnesium Sulfate 1gm/2ml vial		
1	Methylprednisolone, 125 mg		
2	Naloxone (Narcan) 2mg/2ml syringe		
1 Bottle	Nitroglycerin Spray or Tablet 0.4mg		
1Tube or 5 pkgs	Nitroglycerin Paste/ paper (Tube or 1 inch pre-measured foil pkgs)		
1 each	Ondansetron (Zofran) 4mg/2ml vial **and** 4mg ODT		
2	Sodium Bicarbonate 50meq/50ml syringe		
1	Sodium chloride 3%, 500ml bag		
1	Tranexamic Acid 1g/10ml vial (Recommend 50ml Saline bag)		
	IV Fluid: (type/size)_____ _____		

EMS Office Approval: (EMS Coord. or EMSMD Signature)	Date/ Time
Request filled by: (HMMC or SHMC Pharmacy Signature)	Date/ Time
Request picked up by: (Advanced Pre-Hospital Provider)	Date/ Time