Controlled Substance Report for Emergency Medical Services Agencies

• This report must be submitted pursuant to PHL Article 33 and 10NYCRR Part 80 within 30 days following end of each required reporting period.	Reporting Period			
 Complete a separate report for each controlled substance carried Retain a copy of this report for a minimum of 5-years 	All Controlled Substances (Semi-Annual) January 1 - June 30, 20 July 1 - December 31, 20			
Controlled Substance Information	Fentanyl and Ketamine (Quarterly)			
Name	— January 1 - March 31, 20 April1 - June 30, 20			
Dosage Supplied (mg/ml or mcg/ml)	July 1 - September 30, 20			
How Supplied (ampule, vial, syringe, etc.)	October 1 - December 31, 20			

Agency Information

Name		NYS	Agency Code	NYS CS Lice	ense No.	Business	Phone
Address		City		State		Zip	County
Inventory Record			Response/Transport H	listory			
Total Quantity at Start of Reporting Period	Stock: Sub-Stock: Total of Above:		Total Number of EMS Responses and Transports this Period		Respo	nses	Transports
Total Quantity Received Through DEA Registrant			Total Number of Patie Receiving this CS Med		Adult		Pediatric
Total Quantity Administered and Wasted			Number of Quality Ass Reviews Conducted by Service Medical Direct	the	Adult		Pediatric
Total Quantity Returned to Pharmacy or Reverse Distributor			Number of Adverse Retor Adverse Retor Administration	eactions	Adult		Pediatric
Total Quantity Lost (attach copy of DOH-2094)			Total Number of EMS Authorized to Adminis CS Medications		EMT-P		EMT-CC
Total Quantity Accounted from Records (stocks and sub-stocks) Paper Tally			Quantity Carried in Each Sub-Stock		-		
Physical Inventory Count (stocks and sub-stocks) Physical Tally							

* 100% Agency Medical Director Review Required for Fentanyl and Ketamine Administrations Do NOT Attach PCRs to this Form

Attach

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- Any Unusual Incident Reports Involving Controlled Substance Medications and/or Loss (DOH Form-2094)
- Any Reports or Findings of Significant Increases or Decreases in CS Medication Administrations

Comments (attach additional pages as needed)

Any Experienced Shortages of this CS Medication? (if yes, describe)

_(name of CS Agent), certify that on____

(date),

I conducted an actual physical inventory of the controlled substance recorded on this document. Losses have been reported on a "Loss of Controlled Substance Report" DOH-2094 and have been submitted to BNE and a copy of the form has been enclosed. Overages are explained on a separate attached report.

I affirm that this is a true and accurate record of the controlled substance utilization by the agency.

Name of Agent (print)	Signature of Agent	Date
Name of CEO (print)	Signature of CEO	Date
Name of Medical Director (print)	Signature of Medical Director	Date
Send Completed Report to:		
New York State Department of Health Bureau of Emergency Medical Services and Trauma Syste 875 Central Avenue Albany, New York 12206	ems	