East Central Illinois EMS

Expired/Replacement Medication Request Form – Non-Transport ILS

Date: ___________ Agency Name: ____________________________ Unit #: ___________

Contact Person: ________________________________ Contact Number: ________________

Bring expired medications with when picking up new medications

Par Level	Medication	Quantity Needed	Quantity Given by Pharmacy
MAXIMUM	**Controlled Substances**		
2	Fentanyl 100mcg/2ml		
2	Morphine 2mg/ml syringe		
1	Morphine 10mg/ml syringe		
2	Midazolam 5mg/5ml vial		
1	Midazolam 10mg/2ml syringe **(For IN use Only)**		
MINIMUM	**Medications**		
3	Acetaminophen (Tylenol) 325mg tablets		
3	Adenosine (Adenocard) 6mg/2ml		
3	Amiodarone 150mg/3ml		
4	Aspirin, 81mg chewable tablets		
3	Atropine 1mg/10ml pre-filled syringe		
1	Atropine 0.4 mg/ml, 20ml vial (One patient use)		
1	Dextrose 10% (D10) 25g/250ml		
1	Diphenhydramine (Benadryl) 50mg/ml		
2	Diphenhydramine (Benadryl) 25mg tablet		
4	DuoNeb (Albutrol and Ipratropium) 3ml		
1	Epinephrine 1:1000 1mg/ml vial		
4	Epinephrine 1:10,000 1mg/10ml pre-filled syringe		
1	Glucagon 1mg/1unit		
1	Ketoralac, 30mg/ml		
3	Lidocaine 2% 100mg/5ml syringe		
1	Lidocaine 2g/250ml D5W		
1	Methylprednisolone, 125 mg		
2	Naloxone (Narcan) 2mg/2ml syringe		
1 Bottle	Nitroglycerin Spray or Tablet 0.4mg		
1	Nitroglycerin Paste, pre-measured pack		
2	Ondansetron (Zofran) 4mg/2ml vial		
2	Ondansetron (Zofran) 4mg ODT		
2	Oral glucose 15g Tube		

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