



**Client name:**

**Client address:**

**Medication Name:**

**Number of doses delivered:**

**Today's date:**

**Agent:**

1. I confirm that the details above are correct and match the pharmacy/clinic details provided on the actual doses for the client.
2. I confirm I have delivered these medications to the client at the client's specified address today.
3. I confirm I contacted the client by phone and observed the doses being taken into the residence.

.....  
*Agent name (printed) and signature*

.....  
*Witness name if present (printed) and signature*

**Issues identified today:**

**Once completed, this form is to be emailed or a photograph of it texted to the pharmacy/clinic site today.**

### Accessibility

If you have difficulty reading a standard printed document and would like an alternative format, please phone 13 22 81.



If English is not your first language and you need the Translating and Interpreting Service (TIS), please call 13 14 50.

For further accessibility information, visit: [www.health.act.gov.au/accessibility](http://www.health.act.gov.au/accessibility)

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