المرفقات

KINGDOM OF BAHRAIN

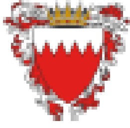
Ministry of Health

مملكة البحرين

وزارة الصحة

KINGDOM OF BAHRAIN

Ministry of Health



مملكة البحرين

وزارة الصحة

بيانات الجهات المصرح لها بالتعامل مع المواد المخدرة والمؤثرات العقلية والسلائف

Controlled Medicine's Health Facility Details

Name of Facility Pharmacy / Hospital / Clinic/Gov. Organization/Company…	
Tel: ______ Fax: ______ E-mail: ______	
NHRA/Animal affair Facility License Number: ______	Expiry Date:
CR Number:	Expiry Date:
Address:	
Health Facility Manager Name:	
License No. (Health Professional only): Sign:	CPR:
Nationality: Age:	Address:
I declare that all information mentioned above are correct and accurate Signature and Stamp:	

Please submit the following Documents:

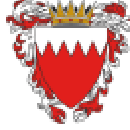
1. Health/Vet Facility license.
2. Physicians /veterinary license.
3. CR License.
4. Manager's CPR card reader information-
5. Pharmacy/vet. Center license.
6. Facility license
7. Delegation letter for assigned person to deal with MOH

مرفق رقم (1)

KINGDOM OF BAHRAIN
Ministry of Health

مملكة البحرين
وزارة الصحة

KINGDOM OF BAHRAIN
Ministry of Health



مملكة البحرين
وزارة الصحة

Psychotropic Drug Purchase License

Serial No. MOH/M-PDPL /   /

Name of Pharmacy / Hospital / Clinic : ______________________

Name of Drug : ______________________

Quantity Requested for Purchase : ______________________

Stock on Hand : ______________________

Original Stock : ______________________

Quantity Consumed : ______________________

N.B.:- Prescriptions/Delivery notes should be enclosed indicating quantity consumed

Requested By:

Date :

For Use By Ministry of Health

Name of pharmacy/Hospital/Clinic : ______________________

Name of Drug & Quantity Approved : ______________________

____

Valid to: ______________

Approved By

مرفق رقم (2)

KINGDOM OF BAHRAIN MINISTRY OF HEALTH DIRECTORATE OF MATERIALS MANAGEMENT	أستمارة إعادة / نقل المواد **MATERIALS RETURN/TRANSFER FORM**	مملكة البحرين وزارة الصحة إدارة المواد

التاريخ DATE	رمز المستخدم لمقدم الطلب USER CODE	اسم القسم /الوحدة SECTION/DEPARTMENT NAME
/ /		

الرقم NO	رقم المخزون STOCK NO	المواصفات DESCRIPTION	الوحدة UNIT	الكمية QUANTITY	الملاحظات REMARK

RETURN/TRANSFER BY: النقل والإعادة بواسطة:	AUTHORIZED BY: صرح الطلب:	RECEIVED BY: استلم بواسطة:
NAME:.................... :الاسم	NAME:.................... :الاسم	NAME:.................... :الاسم
TITLE:.................... :الوظيفة	TITLE:.................... :الوظيفة	TITLE:.................... :الوظيفة
SIGNATURE:.................... التوقيع	SIGNATURE:.................... التوقيع	SIGNATURE:.................... التوقيع
TELEPHONE NO:.................... :رقم الهاتف	TELEPHONE NO:.................... :رقم الهاتف	TELEPHONE NO:.................... :رقم الهاتف

مرفق رقم (3)

Stock Movement Record

Name of Vet Health Facility:

Product Name & Strength:

Date (Recevie/Dispense)	License Number (NDPL/PDPL/PPL)	supplier	Quantity Received	Pet Species	pet owner CPR	Quantity Administered	Quantity Balancce	physician signature	Nurse Signature	Remark

Signature and Stamp : ---------------------

مرفق رقم (4)

KINGDOM OF BAHRAIN
Ministry of Health

مملكة البحرين
وزارة الصحة

Controlled Medicines Request Form

Location Name/Number : --

☐ supply Request ☐ Return Request

No.	Medicine Descreption	Quantity Available				Quantity Required	Quantity Approved (supplier use)			
		QTY	Exp Date	Lot No.	Brand Name	QTY	QTY	Exp Date	Lot No.	Brand Name
1										
2										
3										
4										
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										

Fill only for supply request

Requested By:
Name:--------------------------------------
Tiltle:---------------------------------------
Date:---------------------------------------
Signature:----------------------------------

Prepared By:
Name:---------------------------------------
Date:--
Tiltle:---------------------------------------
Signature:------------------------------------

Received By:
Name:---------------------------------------
Date:---------------------------------------
Tiltle:--------------------------------------
Signature:---------------------------------

مرفق رقم (5)

Stock Movement Record

Name of Department /ward:---------

page No.-------------

Product Name & strength:

Date of Receving/ returning/administration	Order No.	Quantity Received (IN)	QUANTITY RETURNED	QUANTITY ADMINISTER (Dose)	Time	WARD BALANCE	patient Name	CPR NO	ADMINISTRATION: NURSE Given BY	ADMINISTRATION: witnessed By	RECEIVING: SUPPLIER Signature	RECEIVING: Receiver Signature	Remark/ REASON OF RETURNING ORDER STATUS
Date of receiving													include expiry date and batch no
DATE OF ADMINISTRATIO													include expiry date and batch no
DATE OF RETUENING													include expiry date and batch no

Signature and Stamp : ---------------------

مرفق رقم (6)

ward medical order

Name of Department/ward :-----------

Page No.--------

Date of issuing medical order	Order No.	Prescriber Name	patient Name	patient CPR	Medicines Description	Dose/ Frequency	Duration of Treatment	order status active /cancelled	Date of order cancelation	prescriber Name	Nurse Name	Remark

Signature and Stamp : ---------------------

نموذج رقم (7)

KINGDOM OF BAHRAIN
Ministry of Health
مملكة البحرين
وزارة الصحة

Controlled Drug Transfer Form

استمارة نقل الأدوية المخدرة والمؤثرات العقلية والسلائف

Serial No. MOH / TRANS /   /

No.	Drug Description اسم وتركيز الشكل الصيدلاني للدواء	Lot.no. رقم التشغيلية	Expiry Date تاريخ إنتهاء الصلاحية	Quantity (In unit) الكمية محسوبة بالوحدة الواحدة	Transfer From نقل من	Transfer to نقل إلى	Reason of Transfer سبب النقل
1							
2							
3							
4							
5							
6							

Prepared by: أعد بواسطة	MOH AUTHARIZATION: اعتماد الصحة	Received by: استلم بواسطة
Name:	Name:	Name:
Signature:	Signature:	Signature:
Date:	Date:	Date:

اعتماد وزارة الصحة النهائي	MOH Final Approval
Employee Name اسم الموظف	
Date التاريخ	

Stock Movement Records for both parties should be submitted/يجب إرفاق سجلات الطرفين

Original with the Receiver, copy for sender & M

مرفق رقم (8)

KINGDOM OF BAHRAIN

Ministry of Health

مملكة البحرين

وزارة الصحة

Medical Order Form

Health Facility Name:	Department/Ward Name&No.:
Patient Name:	Address:
ID No. Age:	Contact No.
Diagnosis :	

#																			
1	Medicine Description & Strength :			Date															Discont Date:
	Dose	Route	Date	Time															
				Nurse Name & Signature															Dr's Sig & Stamp:
	Doctor's Signature & Stamp :																		
2	Medicine Description & Strength :			Date															Discont Date:
	Dose	Route	Date	Time															
				Nurse Name & Signature															Dr's Sig & Stamp:
	Doctor's Signature & Stamp :																		
3	Medicine Description & Strength :			Date															Discont Date:
	Dose	Route	Date	Time															
				Nurse Name & Signature															Dr's Sig & Stamp:
	Doctor's Signature & Stamp :																		
4	Medicine Description & Strength :			Date															Discont Date:
	Dose	Route	Date	Time															
				Nurse Name & Signature															Dr's Sig & Stamp:
	Doctor's Signature & Stamp :																		

مرفق رقم (9)

Quarter Report / Year : ----------

Facility Name : ------------------------------

Quarter No.: ------------------------------

No.	Controlled Medicine Description	Received + Opening Balance	Consumed	Remaining	Remarks
1					
2					
3					
4					
5					
6					
7					
8					

Signature: ------------------------------ Stamp: ------------------------------

Note: Submit two copies of each report

نموذج رقم (10)

KINGDOM OF BAHRAIN
Ministry of Health

مملكة البحرين
وزارة الصحة

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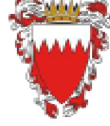
Ministry of Health



مملكة البحرين
وزارة الصحة

UNDER CONTROL DRUG SECTION
Registration Form

CPR NO.									
Full Name									
License No. (NHRA)		License Issue Date		License Expiry Date					
Email address:									
Contact Number:									
Institute Name		Date of Joining							
Profession		Specialty							
Authorized Signature		Stamp							

I hereby confirm that all the information given above is true to the best of my knowledge.

Signature: ______________________________________ Date: ________________

مرفق رقم (11)

KINGDOM OF BAHRAIN

Ministry of Health

مملكة البحرين

وزارة الصحة

KINGDOM OF BAHRAIN

Ministry of Health

مملكة البحرين

وزارة الصحة

Non – Conformity Report

Department of Narcotic and precursors

NCR Number:	Health	Indust ☐	Vet ☐	Others ☐	☐
Non-Conformity Description:				N.C. Code:	
Observer Staff Name:			Group		
Issued To				Issued Date:	
Information of the Non-Conformity Incidence					
Place of (Incidents/observation):			Date of the occurrence..........................		
Other Parties in incidents:					
Non – Conformity (i.e., What is Wrong):					
Justification / Case Analysis (For Facility use):					

Ministry Of Health ,P.O.Box 12, Flat 42, Floor 4, Email: cnsp@health.gov.bh , Tel:17286105

KINGDOM OF BAHRAIN

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مملكة البحرين

وزارة الصحة

Action Taken / Corrective Action (For Facility use):

For Facility use: (N.B. Submit this form to department of Narcotic and precursor by completion)

Date: ....

Name: .... Signature & Stamp: ....

Ministry Of Health ,P.O.Box 12, Flat 42, Floor 4, Email: cnsp@health.gov.bh , Tel:17286105

المرفق رقم (12)

KINGDOM OF BAHRAIN
Ministry of Health

مملكة البحرين
وزارة الصحة

Controlled Drugs Destruction Form

Form (A)

Serial No.____________ Application Date:..........................

Pharmacy/Agent/Hospital/Clinic Name:..........................

Address:.................. Tel.:.................. E-mail:..................

Applied by Health Facility Staff:..........................

License Number:..................

CPR Number:..................

Signature:..................

Stamp

Proposed Date of Destruction:..........................

Proposed Time of Destruction:..........................

Site of Destruction Ward/Section (if Applicable) etc.:..........................

Perform by Health Care Professional Name:..........................

License Number:..................Signature:..................

Witness by Health Care Professional Name:..........................

license Number:..................Signature:..................

Witness and Authorized by Facility Manager (Name):..........................

license Number (if Health Care Professional):..................Signature:..................

List of Controlled Medicines for Destruction.

No.	Brand Name	Generic Name	Strength	Form	Quantity	Batch No.	Expiry Date	Manufacture
1								
2								
3								
4								
5								

Ministry of Health Use:

We Hereby to Permit the Destruction of the Attached Listed Medicines.

Date:.............. Name:.................. Signature:..................

Final Approval Signature:..................

Stamp

مرفق رقم (13)

KINGDOM OF BAHRAIN

Ministry of Health

مملكة البحرين

وزارة الصحة

KINGDOM OF BAHRAIN Ministry of Health مملكة البحرين وزارة الصحة

Controlled Drugs Destruction Form

Form (B)

Serial No.__________

Application Date : ....

Pharmacy/Agent/Hospital/Clinic Name : ....

Address: .... Tel.: .... E-mail: ....

Applied by Health Facility Staff: ....

License Number : ....

CPR Number : .... signature : ....

Manager Approval sign. : ....

Stamp

List of Controlled Medicines for Destruction.

No.	Brand Name	Generic Name	Strength	Form	Quantity	Batch No.	Expiry Date	Manufacture
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								

KINGDOM OF BAHRAIN Ministry of Health مملكة البحرين وزارة الصحة

Ministry of Health Use :

We Hereby to Permit the Destruction of the Attached Listed Drugs.

Date : ....

Name : .... Signature : ....

Final Approval Signature: ....

Stamp

Waste Management Company Use :

Company Name: ....

This is to Declare that we Received and Destroyed the Attached Listed Drugs.

Method of Destruction : ....

Date of Destruction : ....

signature : ....

Stamp

المرفق رقم (14)