RECORD OF MEDICATION RETURNED TO PHARMACY FOR DISPOSAL
This form must always be completed when returning a service user's unwanted or discontinued medicines to a Pharmacy for destruction

Name of service user: _____
Address: _____
Complete Table 1 or 2 which ever is appropriate

Table 1

DATE	MIXTURE OF REFUSED MEDICATION	REASON FOR RETURN
	YES/ NO	

OR

Table 2

DATE	MEDICATION (Name and strength)	QUANTITY (if known)	REASON FOR RETURN (e.g. out of date)

I understand that some of my medicines are out of date or are no longer needed by me. I allow my care assistant to remove these medicines and I understand that he / she will dispose of them at the Pharmacy on my behalf.

SIGNATURE OF SERVICE USER _____

SIGNATURE OF CARE ASSISTANT _____

DATE _____

For completion by the Community Pharmacy

I …….. confirm receipt of the medicines listed above, which have been returned to me for safe destruction.

Signature of Community Pharmacist/ Technician: ……..
Date: ……..

Pharmacy Stamp