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

Name of service user: ______________________________
Address: ____
Complete Box 1 or 2 which ever is appropriate

Box 1

DATE	MIXTURE OF REFUSED MEDICATION	REASON FOR RETURN
	YES/ NO	

OR

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DATE	MEDICATION (Name and strength)	QUANTITY (if known)	REASON FOR RETURN (e.g. out of date)

I understand that some of my medicines are out of date or are no longer needed by me.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 ____________________________

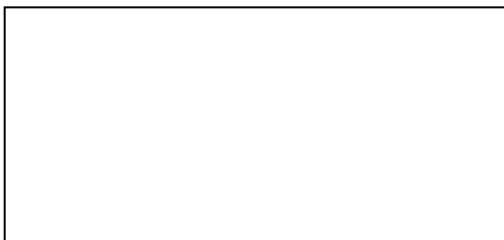
SIGNATURE OF CARE ASSISTANT ____________________________

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