





**RECORD OF MEDICATION RETURNED TO PHARMACY FOR DISPOSAL**

**This form must always be completed when returning an individual’s unwanted or discontinued medicines to a Pharmacy for destruction**

**Name of individual: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complete Box 1 or 2 whichever 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| **DATE** | **MEDICATION****(Name and** **strength)**  | **QUANTITY** (if known) | **REASON FOR RETURN** **(e.g. out of date)** |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I understand that some of my medicines are out of date or are no longer needed by me.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 Support Worker to remove these medicines and I understand that they will dispose of them at the Pharmacy on my behalf.

SIGNATURE OF INDIVIDUAL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:

SIGNATURE OF SUPPORT WORKER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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