Consent to Return
Unwanted or Discontinued Medication

Consent form to return unwanted or discontinued medication to the pharmacy/dispensing GP Surgery for safe disposal.

Customer Name: _____

I authorise that: _____ can take the following medicines to the pharmacy/GP dispensing practice, for destruction

Name, strength & form of medicine	Quantity

Customer Signature: _____Date: _____

If you are unable to sign this form, please tick here: ☐ *and ask someone to sign it on your behalf.*

Name (in capitals): _____

Relationship to customer: _____

Signature:_____. Date:_____

For Pharmacy Use Only		
Name of Pharmacist:		
I confirm that the medicines listed above have been handed over for destruction		
Signature:		Date:
Address/stamp		