Consent to Return Medication

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

I (name of person) _____agree that the following medicines can be removed from my home and returned to a local pharmacy/GP dispensing practice, for safe disposal by _____(name of care staff)

Signed: _____ Dated: _____

Name, Strength & Form of Medicine	Quantity

For Pharmacy Use Only

Pharmacist's name			
I confirm the medicines listed above have been handed over for destruction			
Signed		Date	
Pharmacy Address or stamp			