



MEDICATION RETURNS

RX NUMBER	DATE DISPENSED	MEDICATION NAME/STRENGTH/FORM	QUANTITY RETURNED	REASON FOR RETURN
				<input type="checkbox"/> Order Dc'd <input type="checkbox"/> Order Changed <input type="checkbox"/> Resident Discharged <input type="checkbox"/> Resident Expired <input type="checkbox"/> Uses Other Pharmacy <input type="checkbox"/> Receives From Hospice <input type="checkbox"/> Disposed <input type="checkbox"/> OTHER (Please explain OTHER): _____
				<input type="checkbox"/> Order Dc'd <input type="checkbox"/> Order Changed <input type="checkbox"/> Resident Discharged <input type="checkbox"/> Resident Expired <input type="checkbox"/> Uses Other Pharmacy <input type="checkbox"/> Receives From Hospice <input type="checkbox"/> Disposed <input type="checkbox"/> OTHER (Please explain OTHER): _____
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Staff Signature

Date

Resident Name

Facility