Get Rid of Our Unused Pharmaceuticals (GROUP)
Medicine Return Form©

INSTRUCTIONS: Please complete this form by getting the information directly from your prescription labels, pill bottles, or medicine packages. **1**. Write the date of return. **2**. Write your zipcode. **3**. Write the name of each medicine you are returning. **4**. Write the strength or dosage of each medicine. **5**. Estimate the number of pills, or amount of liquid, cream, etc." **6**. Check box with "**X**" for where you got each medicine. **7**. Check box with "**X**" for a reason you are returning each medicine. **8**. If the medicine is returned because of a side effect, please write down the side effect or any comment in this space. Please also indicate if medicine was UNOPENED!

Take-Back Location: (filled out by staff) _____						**6. Where did you get this medicine? Check one box below.**								**7. Why was medicine returned? Check one box below.**									
1. Date of Return	**2. Your Zip code**	List medicine(s) from pill bottle or package. **3. Name of Medicine**	Supplement or vitamin?	Write the strength of the medicine (e.g., 30 mg, 2%) **4. Dosage**	Approx. number of pills, or estimate amount of liquid or cream **5. Quantity**	Doctor's office	Pharmacy	Hospital or clinic	Family or friend	Mail order (prescription plan)	Mail order (private pay)	Internet (online order)	Don't know or other	Expired or outdated	Discontinued by Doctor	Doctor ordered new medicine	Patient felt better	Side effects or allergic reaction	Patient died or moved away	Did not want to take it	Don't know or other	If you have had a bad side effect with your medicine and stopped taking it, list the side effect(s) for each medicine. **8. Indicate side effects or other comments**	**(staff only, where needed) REASON NOT TAKEN,** Inhaler or Controlled Substance or Other Reason (list)

9. Staff only, indicate if medicine was not taken and why.

Copyright 2006, Community Medical Foundation for Patient Safety (CMFFORM0019-UEMR Individual Anonymous Return Form, Rev 09-22-06)