

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.** Write the number of pills, capsules, tablets, or amount of liquid of each medicine. **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. **9.** Pharmacists, note reason for not taking medicine.

Take-Back Location: (filled out by a pharmacist) _____						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	3. Name of Medicine (check box if it is a supplement/vitamin)	4. Dosage	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friend	Mail order (prescription plan)	Mail order (private pay)	Internet (online order)	Don't know or other	Expired or outdated	Discontinued by Doctor	Doctor ordered new medicine	Patient felt better	Side effects or allergic reaction	Patient died or moved away	Did not want to take it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	8. Indicate side effects or other comments	9. Reason not taken (staff only, where needed)	