**Care Home Medication Returns Form**

This form must be completed for all medicines being returned to community pharmacy. Returns will only be accepted by drivers if accompanied by a signed form.

|  |  |
| --- | --- |
| Care Home name: |  |
| Date of returns: |  |

**I verify that the medication returns have been checked by myself as care home manager (or deputy in the absence of the manager) and meet the NHS Borders procedure for medication returns and wastage.**

**C:\Users\dmacbrayne\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\R3AHZOQR\364px-Tick_green_modern.svg[1].pngReturns only include:**

**Medication that has been stopped by the clinician**

**Medication date expired**

**Medication from deceased patients**

**Other appropriate waste (specified)**

**C:\Users\dmacbrayne\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\I4XPJ2WJ\red-40144_640[1].png No medication has been returned that is still in date and which the patient is currently prescribed.**

* **Food supplements, non-medicated dressings and appliances such as catheters or stoma bags can be disposed of in the general waste providing all patients identifying material, i.e. dispensing label, has been removed.**
* **Medication returns are fully documented on the returns sheet for each patient with a valid reason (attached).**

|  |  |
| --- | --- |
| Managers name: |  |
| Position: |  |
| Signature: |  |
| Date: |  |
| Name of person assembling medication for return: |  |
| Signature: |  |