Dakota Pharmacy

Medicine Return Form

INSTRUCTIONS: Please complete this form by getting the information directly from your prescription labels, pill bottles, or medicine packages.

Date of Return:		**Zip Code:**		**medicine? Check one box below.**								**returned? Check one box below.**									
List medication(s) from pill bottle or package. **Name of Medicine.**	Supplement or Vitamin?	Write the strength of the medicine (e.g., 30mg. 2%) **Dosage**	Approx. number of pills, or estimate amount of liquid or cream. **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Friend	Mail Order (Prescription Plan)	Mail Order (Private Pay)	Internet (Online Order)	Don't know or other	Expired or Outdated	Discontinued by Doctor	Doctor ordered new medicine	Patient felt better	Side effects or allergic reaction	Patient died or moved away	Did not want to take	Don't know or other	If you had a bad side effect with your medicine and stopped taking it, list the side effect(s) for each medicine. **Indicate side effects or other comments**	(Staff Only, where needed) **REASON NOT ACCEPTED** Inhaler or Controlled Substance or Other Reason (list)