# Appendix Four - MEDICINES DISPOSAL FORM

I give my permission for the following medicines to be removed from my home by

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ my Care Worker, for safe disposal by the local pharmacist.

|  |  |
| --- | --- |
| **Name of Drug** | **Quantity (approximate)**  *(Pharmacist to check quantity of CD.s and initial)* |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |  |
| --- | --- |
| **Name and Address of service user:** |  |

|  |  |
| --- | --- |
| **Signature of service user/ Representative** |  |
| **Date** |  |

**FOR PHARMACY USE ONLY**

|  |  |  |  |
| --- | --- | --- | --- |
| **I,** |  | | (Pharmacist) confirm the above drugs have been handed in for disposal. |
| **Signed** | |  | |
| **Pharmacy** | |  | |
| **Date** | |  | |