Medication Return Form

Patient Name _____ Date: _____

Rx# _____ Medication Name: _____

Reason For Return (Check Appropriate Box):

☐ 1. Repackage (Reship to Facility) Due to Order Change (Attach Copy of New Order)
Spoke to Data Entry Dept. Date/Time/Name: _____
Detailed Instructions: _____

☐ 2. ERROR!! Incorrect Med/Dose/Strength - Details: _____

☐ 3. SNF ONLY - Medication Discontinued (Attach Copy of Discontinued Order)

☐ 4. Please Circle One: Patient Discharged or Patient Deceased

Form Completed By: _____

Guardian Pharmacy - St. Cloud MN Phone 320-230-1050 Fax 855-502-1051