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Form
Unused Medication Return
Residential Care and Transition Services

Child/YP details	
Name	
D.O.B.	
Program	
Pharmacy	
Medication Issue Date	e.g., date medication was intended to be administered
Medication Return Date	e.g., date medication is returned to pharmacy

Medication Details	
Medication Name	e.g, Ritalin
Medication Form	e.g., Tablet
Medication Dosage	e.g., 20mg
Amount of Medication Returned	e.g, 2 x 20mg tablets
Reason for Return	e.g., contaminated when dropped on floor

Medication Details	
Medication Name	e.g., Children's Panadol
Medication Form	e.g., tablet
Medication Dosage	e.g., Paracetamol 120mg per tablet
Amount of Medication Returned	e.g., 8 tablets
Reason for Return	e.g., expired

Medication Details	
Medication Name	
Medication Form	
Medication Dosage	
Amount of Medication Returned	
Reason for Return	

Confirmation			
By signing below, you are confirming that the unused medication/s listed above have been returned to the issuing pharmacy.			
Role	Name	Signature	Date
RCW			
Pharmacist			