Daly Drug LTC Returned Medication Form

Patients Name:	Rx Number:	Date Rx was filled:	Drug Name:	Qty:	Reason for Return: (If Discontinued a copy of that order must be attached)

Facility Name:_____

Employee Name:_____Date:_____

DC Order provided_____Yes _____ No

<u>NO</u> medications will be accepted or picked up without this form being filled out.

Thank you!