Get Rid of Our Unused Pharmaceuticals (GROUP)
Medicine Return Form©

INSTRUCTIONS: Please complete this form by getting the information directly from your prescription labels, pill bottles, or medicine packages. If you need more space, use another form or make a blank copy of this form. **1**. Write your zip code. **2**. Write the date of return. **3**. Write the name of each medicine you are returning. **4**. Write the strength or dosage of each medicine. **5**. Write the number of pills, capsules, tablets, or amount of liquid of each medicine. **6**. Check box with "**X**" for where you got each medicine. **7**. Check box with "**X**" for a reason you are returning each medicine. **8**. If the medicine is returned because of a side effect, please write down the side effect or any comment in this space.

1. Your Zip Code:	**2. Date of Return:**		**6. Where did you get this medicine? Check one box below.**								**7. Why was medicine returned? Check one box below.**								
List medicine(s) from pill bottle or package. **3. Name of Medicine**	Write the strength of the medicine (e.g., 30 mg) **4. Strength (Dosage)**	Write approx. number of pills or capsules or amount of liquids you are returning **5. 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friend	Mail order (prescription plan)	Mail order (private pay)	Internet (online order)	Don't know or other	Expired or outdated	Discontinued by Doctor	Doctor ordered new medicine	Patient felt better	Side effects or allergic reaction	Patient died or moved away	Did not want to take it	Don't know or other	If you have had a bad side effect with your medicine and stopped taking it, list the side effect(s) for each medicine. **8. Indicate side effect or other comments**

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