Your consent for us to destroy your unwanted or discontinued medicines

I authorise that you can take the following medicines to the local pharmacy or GP dispensing practice for destruction.

|  |  |
| --- | --- |
| **Medicine Name**  | **Quantity** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Service User Signature: Date:

If you are unable to sign this form, please get someone to do it on your behalf.

Signature of Representative: Date:

Name of Cumbria Care staff member returning the medication:

Date:

|  |
| --- |
| **FOR PHARMACY USE ONLY**I (Pharmacist’s name) confirm the medicines listed above have been handed over for destruction. Signature: Date:Pharmacist’s address: |