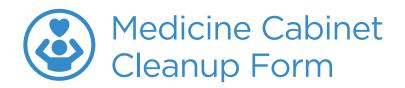


Caregiver Support



Patient Name: \_\_\_\_\_

Health Care Number: \_\_\_\_\_

I authorize the Medicine Shoppe Pharmacist to review my collection of Medications (prescription, non-prescription, natural health products) in my home to determine if they are appropriate and safe.

If they are not, I authorize the pharmacy to remove these medications from my home for safe disposal at the pharmacy.

Date of Medicine Cabinet Cleanup: _		
Patient Signature:	Date:	

Pharmacist	
Signature:	Date:

	NAME OF DRUG	QUANTITY	KEEP (√)	REMOVE (X)
1				
2				
3				
4				
5				
6				
7				
8				
9				
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