The Medicine Shoppe PHARMACY

Caregiver Support

Medicine Cabinet Cleanup Form

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				
10				
11				
12				
13				
14				
15				
16				
17				
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19				
20				