PharMerica®
Senior Living

CYCLE MEDICATION REFUSAL FORM

FILL OUT THIS FORM AND SUBMIT A COPY WITH MEDICATIONS TO BE RETURNED.

Facility: A0000 Sample Facility

Staff Name (print): Date:

AFFIX REORDER LABEL BELOW	REASON - Check One	QUANTITY
RX # NAME MED NAME	☐ Discontinued ☐ Order Changed ☐ Discharged ☐ Family Provides ☐ Other ______________________	
RX # NAME MED NAME	☐ Discontinued ☐ Order Changed ☐ Discharged ☐ Family Provides ☐ Other ______________________	
RX # NAME MED NAME	☐ Discontinued ☐ Order Changed ☐ Discharged ☐ Family Provides ☐ Other ______________________	
RX # NAME MED NAME	☐ Discontinued ☐ Order Changed ☐ Discharged ☐ Family Provides ☐ Other ______________________	
RX # NAME MED NAME	☐ Discontinued ☐ Order Changed ☐ Discharged ☐ Family Provides ☐ Other ______________________	
RX # NAME MED NAME	☐ Discontinued ☐ Order Changed ☐ Discharged ☐ Family Provides ☐ Other ______________________	

If an order has changed, please ensure the pharmacy has the new order.

PLEASE SEE RETURN GUIDELINES BEFORE SUBMITTING RETURNS