**SCHEDULE 8 RETURN REQUEST**

**Section 1: to be completed prior to emailing/faxing to the pharmacy**

Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Wing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Schedule 8 Medicines (S8s) for Return:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Stock from** | **Drug Name** | **Form** | **Strength** | **Quantity** | **Reason for Return** |
| e.g. ‘Facility Imprest stock’ or fill in resident name  |  |  |  |  | e.g. expired, no longer required or recalled |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
RN Full Name Witness\* Full Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
RN Signature Witness\* Signature

*\*Witness must be a facility staff member; pharmacy staff are not authorised to witness controlled drug movement.*

This form was emailed/faxed to *(insert pharmacy name)* on \_\_\_/\_\_\_/\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Date Time

**Section 2: to be completed upon collection of the S8 package**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ confirm that the sealed package has been collected
 RN Full Name
by the below mentioned [name of pharmacy]employee on \_\_\_/\_\_\_/\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date
RN Signature

[name of pharmacy] employee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Name

 \_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Date Employee Signature

**Section 3: Pharmacy acknowledgement of receipt of S8s**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received returned controlled drugs in full on the
 Pharmacist full name

\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Date Pharmacist Signature