ROCKHILL PHARMACY
LONG TERM CARE SERVICES

MEDICATION CREDIT FORM

Facility: _____ Date: _____

Resident Name: _____

Medication(s) Returned for the Following Reason(s):

   1) Order Discontinued   2) Resident Discharged/Deceased   3) Excess Supply   4) Other (please specify)

RX NUMBER	DISPENSE DATE	MEDICATION / STRENGTH	QTY	REASON FOR CREDIT

Witnessed By: _____   _____
                                      Name / Title   Date

Witnessed By: _____   _____
                                      Name / Title   Date