	HOSPITAL SULTAN ABDUL AZIZ SHAH **UNIVERSITI PUTRA MALAYSIA** **Kod Dokumen: HSAAS/FAR/BR214**
	RETURN MEDICATION FORM (INPATIENT)

Ward/Clinic/ Unit :…….

Patient's details (COMPULSORY to fill for **FPP patient**)	**Reason for return (**Please tick (√) at appropriate box**)**
Patient Name : ……. Identification No : ……. MRN No : …….	☐ FPP Patient ☐ Dangerous Drug (DD) ☐ Fridge items / Expired drugs

No.	Drug Name & Strength	Quantity	Cold Chain Drug (Yes/ No)	Expiry Date	Batch No.

Return medication form must be sent together with medication listed above.

Prepared by (Ward):

_____
(Signature/ Nurse Stamp)
Date:

Received by (Pharmacy):

_____
(Signature/ Stamp)
Date:

Checked by (Pharmacy):

_____
(Signature/ Stamp)
Date: