Right Dose
A Guardian Pharmacy®

Medication Release/Receipt

☐ Leave of Absence | Dates/Times From _____ To _____ | ☐ Move Out/Discharge | Date

Person Responsible for assisting/administering medication

_____

Name of Medication	Total # Of Pills/Amt Of Medication	Dose	Frequency	Total # Of Pills/Amt Returned

Special Instructions

Information about the medication regimen (including side effects) were reviewed with the family/responsible party by the nurse? __ Yes __ No

Telephone Numbers

Physician _____
Name/Title of Person Completing Form
_____

Right Dose Pharmacy
Ankeny **(515) 963-1640**
Cedar Rapids **(319) 214-5265**

Facility_____
Signature
_____

Family Responsible Party Statement

I understand these medications are NOT in childproof containers unless otherwise noted. I understand and accept responsibility of this medication regimen and have taken possession of these medications for the:
__ Leave of Absence __ Move out/Discharge as stated above.

Signature of Responsible Party _____ Date _____ Nurse Signature _____ Date _____

LOA Return Information

Date/Time Returned _____

Any unusual medication-related experience _____

Explain

_____

_____

Resident Name – Last _____ First _____ Middle _____ Attending Physician _____ Record No. _____ Room/Bed _____