

**SIRUM****Fax this sheet to (888) 858-8172****1. BY SIGNING BELOW, I attest that to the best of my knowledge the donated drug(s)**

A) have been properly stored, in accordance with the manufacturer's recommendations, and have never been opened, used, adulterated or misbranded AND

B) since originally dispensed, the donated drug(s) have been in the possession of a pharmacy, skilled nursing facility, intermediate care facility or trained staff.

**2. PICKUP LOCATION**

Front Office

Nursing Station

DON Office

Other

*No Need - We Already have them picking up*

NAME

*Jackie Dean*

TITLE

*Purchasing Supervisor*

CELL # (optional) ( ) -

SIGNATURE

*Jackie Dean*

DATE

*8-20-15*

TOTAL # OF BOXES

*1*

Peel Label HERE

**CIRCLE SUPPLIES NEEDED** (optional)**Shipping Labels**

Boxes

Padded envelopes

Packing tape

Sharpies

**THANK YOU! FEDEX WILL COME  
THE NEXT BUSINESS DAY**

Tracking #971424215098178 - D755R719T5763P

Consonus Pharmacy Services  
4560 Se International Way, Suite 101, Milwaukie,  
OR 97222Central City Concern Pharmacy  
727 W Burnside St, Portland, OR 97209**CONFIDENTIALITY NOTICE:** The documents accompanying this fax may contain confidential patient health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing information to any other party unless required or allowed to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited by law. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

# Medication Donation Form

## Donor Information

Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Drug Name	Drug Strength	Qty	Lot #	Expiration Date

By signing below, I attest that to the best of my knowledge the drug(s) listed above have been properly stored, in accordance with the manufacturer's recommendations, and have never been opened, used, adulterated or misbranded. They have been in the possession of:

☐ Patient    ☐ Donor    ☐ Other: \_\_\_\_\_; since originally dispensed.

Donor Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### For Pharmacy Use

Is the medication in the original sealed container or in a sealed bubble pack?      **YES**      **NO**

Is the medication available over-the-counter?      **YES**      **NO**

Is the medication a controlled substance?      **YES**      **NO**

Does the medication require refrigeration?      **YES**      **NO**

Does the medication expire in less than 9 months?      **YES**      **NO**

Does the medication appear safe for dispensing?      **YES**      **NO**

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