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Date of Return: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Prescription(Rx) # located on prescription bottle	Name & Dosage of Medication please list medication(s) from the bottle or package with the strength (e.g., 30 mg, 2%)	Quantity	Address of Dispensing Pharmacy Please list the address of the pharmacy at which the medication was dispensed - located on the prescription label	Where did you get this medicine? Check one box below.							Why was medicine returned? Check one box below.						
				Doctor's Office	Pharmacy	Hospital or Clinic	Family or Friend	Mail Order	Don't Know or Other	Expired or Outdated	Discontinued by Doctor	Patient Felt Better	Side effects/allergy	Patient Passed or Moved	Did Not Want To Take	Don't Know or Other	

1. WE CANNOT ACCEPT CONTROLLED MEDICATIONS.
2. PLEASE DO NOT REMOVE ANY INFORMATION FROM THE PRESCRIPTION VIALS.
3. ALL PRESCRIPTION ITEMS MUST BE IN THEIR ORIGINAL CONTAINERS.
4. WE CANNOT ACCEPT UNLABELED PILLS/VIALS FROM UNKNOWN ORIGIN.

Pharmacist Name: \_\_\_\_\_  
Pharmacist Signature: \_\_\_\_\_