

**Norfolk Medicines Support Service Referral (Form 2)**

This form should be completed by the pharmacy/dispensing surgery ONLY. It is only required when an ongoing referral to Medicines Support is required. The initial referral form (Form 1) and independence assessment tool sheet should also be sent as part of the referral.

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| **Patient Name** |  | | | |
| **Date of Birth** |  | | | |
| **NHS Number** |  | | | |
| Any additional referral reasons/information (not covered on original referral) | | | | |
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| Please indicate score from Initial Independence Assessment Tool | | |  | |
| Has a full medication review been requested from the GP? | | | YES | NO |
| Does the person usually receive a home visit from the GP? | | | YES | NO |
| What has already been tried to assist the person with medication problems?  e.g. information and advice, MUR/DRUM, reasonable adjustments under EA | | | | |
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| Indicate reasons for referral being sent on to Medicines Support  e.g. why the pharmacy/surgery cannot assist the person referred directly | | | | |
| **SUBMIT WITH FORM 1 AND INDEPENDENCE ASSESSMENT TOOL TO NMSS** | | | | |
| **Patient Consent – must be attached** | | | | |
| Please ensure that consent from Form 1 is attached to this referral. We are not able to accept without consent | | | | |
| Pharmacy/dispensary staff name: | |  | | |
| Referrer contact telephone number: | |  | | |
| Pharmacy/surgery date stamp: | |  | | |
| Pharmacy/surgery post code: | |
|  | |

# Please send to secure email: [agem.norfolkmedicineservices@nhs.net](mailto:agem.norfolkmedicineservices@nhs.net)