**Medicines – Difficulty Using/Managing - Referral to Pharmacy/Dispensary**

*Notes to referrer:* complete the form which should be taken or sent to the medication supplier by the patient or their carer.

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| **Patient Name** |       |
| **Address & postcode** |       |
| **Telephone Number** |       | **Date of birth** |       |
| **GP Surgery** |       | **NHS No.** |       |
| **Has the patient recently been in hospital (last month)?**  | **[ ]  YES / NO** **[ ]**  |
| If yes, please give a brief reason why: |
|       |
| **What are the problems that are being experienced with managing medicines?**NB: Please give a full explanation and **do not** request compliance aid (dosette/MDS) at this point, as this is a professional decision for the medication supplier and may not be appropriate. |
|       |
| **Patient Consent – consent to pharmacy/dispensary referral** |
| I agree that a referral can be made to my medication supplier to assist me with my medication. I agree that my relevant medical information can be shared with:* my GP (doctor) to help them provide care for me
* my pharmacy or surgery who provides my medication
* the Norfolk Medicines Support Service if an ongoing referral is needed
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| Signature: | Date:       |
| **If the patient is unable to sign, we MUST have a signature of the person signing on behalf and the reason why to minimise the risk of delay in the referral process, otherwise the referral may be declined** |
| Name of person signing on behalf:      | Relationship to patient:      |
| **Reason patient cannot sign:**       |
| **Has verbal consent been obtained from patient?**  | **[ ]  YES / NO [ ]**  |
| Referrer name: |       |
| Referrer position/occupation: |        |
| Referrer contact telephone number: |       |

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| [**Accessible Information Standards**](https://www.england.nhs.uk/wp-content/uploads/2017/08/accessilbe-info-specification-v1-1.pdf) |
| Please specify below if the **patient** and or **carer**, have additional needs related to: |
|  | **Patient:** | **Carer:** |
| Vision |       |       |
| Hearing |       |       |
| Speech |       |       |
| Other communication difficulties |       |       |
| The patient, and or parent / carer, requires an: |
| [ ]  | Interpreter (*specify language)* |       | [ ]  | Lip speaker  | [ ]  | BSL interpreter |

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| **FOR PHARMACY/DISPENSARY USE ONLY – EA ASSESSMENT** |
| Does the patient have a long-term condition (physical or mental) | [ ]  YES / NO [ ]  |
| Are they able to come to the pharmacy | [ ]  YES / NO [ ]  |
| Is any adjustment for the patient (rather than carer) | [ ]  YES / NO [ ]  |
| *If all 3 answers are YES – EA applies and appropriate reasonable adjustment should be made directly with the patient. If 1+ answers are NO – proceed to independence assessment tool.* |

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| **Form 1- Medicines- Difficulty using/managing- Referral to Pharmacy/Dispensary**  | **Once ALL 3 forms are completed, the 3 forms MUST be emailed to Norfolk Medicines Support at the same time to minimise any delay in acceptance, triage and assessment for patient** **Once completed, email to secure email:** **agem.norfolkmedicineservices@nhs.net** |
| **Form 2 Completed by Pharmacy/Dispensary**  |
| **Independence Assessment Tool form**  |