 

**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** |  | | | | | | |
| **Patient e-mail address** |  | | | | | | |
| **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 by 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 | | | | | | | |
| 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:** | | | | | | | |
| Referrer name: | |  | | | | | |
| Referrer position/occupation: | |  | | | | | |
| Referrer contact telephone number: | |  | | | | | |
| **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.* | | | | | | | |

**Once completed,** **this form should be emailed to secure email** [**agem.norfolkmedicineservices@nhs.net**](mailto:agem.norfolkmedicineservices@nhs.net)