 

 **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
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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:** |
| 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**