 

Registration Form for NMSS MAR Chart

**The Care Provider and Pharmacy/Dispensary to complete form. Once completed, please email this form to NMSS at** [agem.norfolkmedicineservices@nhs.net](mailto:agem.norfolkmedicineservices@nhs.net)

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Name:** | |  | | | Date of Birth: | |  | | |
| Address: | |  | | | Postcode: | |  | | |
| Tel no: | |  | | | NHS No: | |  | | |
| **Care Provider/Agency Details** | | | | | **Usual pharmacy/dispensary details** | | | | |
| Named contact: | |  | | | Name: | |  | | |
| Branch: | |  | | | Address: | |  | | |
| Tel no: | |  | | |
| **GP Surgery:** | |  | | | | | | | |
| *To Supplier: please note if care workers are administering, original packs should be supplied unless with prior agreement by the Support Service Manager.* | | | | | | | | | |
| Are care workers administering **all** medications to the patient? YES | | | | | | | | YES  | NO  |
| If the MAR chart is needed only for certain items that the patient has e.g. eye drops, patches, warfarin etc. please list the required items:  **MAR CHARTS SHOULD NOT BE SUPPLIED FOR EXTERNAL PREPARATIONS – CREAMS ETC.** | | | | | | | | | |
| Do the care visits happen for all times medication needs to be administered? | | | | | | | | | |
| YES  | NO  | If NO please state arrangements for other times | | | | | | | |
|  | | | | | | | | | |
| How long is the MAR chart needed for? | | | Indefinitely  | | | Other: | | | |
| **Agency request to pharmacy/dispensary** | | | | | | | | | |
| The person named above is having medication administered by trained care workers. Please supply a NMSS MAR chart for the requested agency for the purposes of medication administration (Level 2). Please note it is the agencies responsibility to reorder prescriptions unless an alternative arrangement is negotiated and agreed with the supplying pharmacy. | | | | | | | | | |
| **To ensure continuity of supply, the agency MUST confirm with the pharmacy the date on which the current medication supply will be finished – and ensure the prescription for ALL items required on the MAR chart is ordered in time to facilitate this** | | | | | | | | | |
| Signature: | | | | Date: | | | | | |
| Date that current medication will finish: | | | |  | | | | | |
| **Pharmacy/Dispensary Agreement** | | | | | | | | | |
| We will supply a MAR chart to the named patient with each prescription dispensed. I understand we will be issued with a NMSS number, which will be used to claim for payment**. (Please do not register on PharmOutcomes without the NMSS number)**  We will store this request securely for our records. I understand a record of this request will be stored electronically and entered onto the AGEM NHS recording database. | | | | | | | | | |
| Date of supply of first MAR chart: | | | | Script ordering service agreed. Yes / No | | | | | |
| Delivery service? Yes / No  *if no who will be collecting?* | | | | Pharmacy/Practice stamp: | | | | | |
| Name and Position: | | | | Signature: | | | | | |