**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. | | | | | | | | |
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| **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 | | | | | | | | |
| 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**](mailto:agem.norfolkmedicineservices@nhs.net) |
| **Form 2 Completed by Pharmacy/Dispensary** |
| **Independence Assessment Tool form** |