**Norfolk Medicines Support Service (NMSS) Referral Form Assessment for Compliance aid**

**This form should be completed in full.**If any sections are left blank or incomplete, the referral will be declined and returned to the referrer to request more information.

**For more information, please visit our website or get in touch via:**



**Website:** [www.ardengemcsu.nhs.uk/nmss](http://www.ardengemcsu.nhs.uk/nmss)



**Email:** agem.norfolkmedicineservices@nhs.net



**Voicemail:** 01603 257006 / 257007

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| **Patient Details** Please ensure this is filled in accurately to avoid any delay in processing.   |
| **Patient Name:**  |   |
| **Date of Birth:**  |   |
| **NHS Number:**  |   |
| **Address:**  |   |
| **Postcode:**  |   |
| **Telephone Number:**  |   |
| **GP Practice and Address:**  |   |
| **Current Pharmacy/Dispensary:**  |   |
| **Lone Working Concerns** (Please advise of issues that may put assessors at risk of harm or danger) |   |
| **Referrer name:** |    |
| **Referrer position/occupation:** |    |
| **Referrer contact telephone number / email address:** |    |
|   **Patient Consent** This section must be completed. If it is incomplete, the referral will be rejected and sent back to the referrer.   |
| **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 that provides my medication.
* Norfolk Medicines Support Service.

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| **Patient signature:**  |    |
| **Date:**   |    |
| **Verbal Consent** If the patient is unable to sign, we must have the signature of the person signing on their behalf and how the consent was granted, otherwise the referral may be declined. |
| **Has verbal consent been given?** Please delete/tick/highlight the appropriate response.  | **YES**  | **NO**  | **How was consent granted?** E.g., via telephone, face to face  |    |
| **Name of person signing on behalf of the patient:** |    |
| **Contact Information:** (email/telephone)  |   |
| **Relationship to patient:** |    |

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| **Information to support the Referral.** Please give as much detail as possible. A lack of information may result in the referral being declined.  |
| **Please state the problems relating to medication management** (i.e., memory loss or confusion, dexterity issues, physical or mental illness)  |     |
| **Has the patient recently attended hospital?** If yes, please give details.(Please do not include routine appointments)  |    |
| **What has been tried to aid the patient so far?** (i.e., changing to weekly prescriptions, family/friends preparing store-bought weekly trays, social services, etc)  |    |
| **Has the pharmacy/dispensary attempted to intervene or provide any form of assistance?** (Medication Use Review, Medication reminder charts, etc)  |    |
| **Any further information you can give or comments that have not been covered above?**  |    |

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| **Information relating to patient independence.** Tick/highlight the most appropriate statement.(Only one answer per section)  |   **Tick/ highlight** |
| **Mental state**  | Alert & orientated.  |   |
| Orientated but occasionally forgetful. |   |
| Confused / Muddled / Forgetful.  |   |
| Very confused / Very forgetful / Diagnosed Dementia.  |   |
| **Vision**  | Can see/read with no aids.  |   |
| Use glasses/aids to read print.  |   |
| Difficulty reading print with glasses & aids / partially blind. |   |
| Registered blind. |   |
| **Social circumstances**  | Living with others who can fully support medication needs.  |   |
| Living with others who occasionally support medication needs.  |   |
| Living alone with some help from paid carers/family/friends.  |   |
| Living alone with no help.  |   |
| **Dexterity**  | Can manage to open boxes etc. independently.  |   |
| Weakness of hands/poor coordination but can open packaging etc.  |   |
| Disabled. Requires some help to open bottles/packaging. |   |
| Severely disabled and unable to manage any packaging.  |   |
| **Attitude and knowledge of medication**  | Interested in prescribed medication. Knows about them and their importance. Understands how to administer.  |   |
| Fairly interested in prescribed medication. Knows enough about them to administer safely. Believes they are important.  |   |
| Not overly interested in prescribed medication. Displays a lack of understanding surrounding medication regime and its importance.  |   |
| Disinterested and/or unwilling to take prescribed medication. Evidence of mismanagement of medication.  |   |
| **Access to healthcare**  | Attends GP appointments and pharmacy independently without assistance.  |   |
| Can attend GP and pharmacy with assistance  |   |
| If assistance was unavailable, the patient would be unable to attend GP or visit the pharmacy.  |   |
| Fully housebound, GP would usually attend a home visit to the patient. |   |

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| **Pharmacy / Dispensary information**This section is about the patient’s current pharmacy/dispensary and their capacity to provide a compliance aid. If you do not know this information, please contact the pharmacy/dispensary. This section must be completed. If it is incomplete, the referral will be rejected and sent back to the referrer.   |
| **Has the pharmacy/dispensary been contacted prior to this referral?** Please delete/tick/highlight (leave blank if referring from a pharmacy/dispensary)  | **YES**  | **NO**  |
| **Can the pharmacy/dispensary support the delivery of any intervention recommended by the NMSS assessors?****Please provide the name of the staff member who approved this.**Please note, that it is the professional judgment of the assessor to implement a compliance aid if deemed appropriate during the assessment.  |    |
| **If the pharmacy/dispensary can’t support the delivery of any intervention recommended by the NMSS assessors, please advise why.** |    |
| **Does the pharmacy/dispensary offer a delivery service?**  | **YES**  | **NO**  | **If yes, is there a delivery charge?****What is the cost?** | **YES**  | **NO**  | **£** \_\_\_\_\_\_\_\_\_ |
| **Pharmacy/Dispensary name, address telephone number & email address:**  |   |

**End of form**