**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](mailto: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. | | | | | |
| **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**