GLUTEN FREE FOOD REQUIREMENTS
PATIENTS MONTHLY ORDER FORM

Patient Name

Address

Patient Signature

Date

Maximum no of units allowed

	Patient to complete	
Item	Product/Brand	Quantity
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		

Please sign for receipt of your order Date

Patient Consent - I agree for my data to be shared with the NHS Cumbria

Please remember to pick up next month's order form

GFS01
Mar 11

PHARMACY USE ONLY

Pharmacy Patient Identification

Pharmacy Stamp

Please ensure that forms are completed in full for each patient.

Pharmacist Signature

Pharmacy Use Only			
Unit Value	List Price	Quantity x List Price	P+P per delivery
A Total		B Total	C Total

Exempt Charges	Yes / No	
Prepayment certificate	Yes / No	
Prescription Charges paid		

D Dispensing Fees	
E Initial Set Up Fee	
F Total	
G Less Rx ChargesPaid	
H Total Claimed	

NHS Community Pharmacy
Enhanced Service ES009 – Gluten Free Food

Patient declaration of charges paid or exemption from charges –
to be completed on every occasion a supply is made.

The patient doesn't have to pay because he/she

A is under 16 years of age
B is 16,17,18 and in full time education
C is 60 years of age or over
D has a valid maternity exemption certificate
E has a valid medical exemption certificate
F has a valid prescription prepayment certificate
G has a valid War Pension exemption certificate
L is named on a current HC2 charges certificate
H gets income support
K gets income based Jobseekers Allowance
M is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
S has a partner who gets Pension Credit guarantee credit

OR I have paid £…………

Declaration:
I declare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by the NHS Business Services Authority, the NHS Counter Fraud and Security Management Service, the Department for Work and Pensions and Local Authorities.

Signature………………………………………….Date………./……/……… .