**COPD Rescue Pack Supply Service – Record and consent form**

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| --- |
| Patient’s details |
| First name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Surname |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | Postcode |  |  |  |  |  |  |  |  |
| Date of birth |  |  |  |  |  |  | NHS Number |  |  |  |  |  |  |  |  |  |  |
| GP practice |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Medicines supplied |
| Medicine  | Tick box |
| **Corticosteroid:** Prednisolone 5mg tablets x [42 or 84 depending on what the local arrangements recommend] |[ ]
| **Antibiotic (select one):** |  |
| Amoxicillin 500mg capsules x 15 |[ ]
| Doxycycline 100mg capsules x 6 |[ ]
| Co-amoxiclav 500/125mg tablets x 15 |[ ]
|  |
| Additional comments: |
| Name of pharmacist authorising supply |   | Pharmacy stamp |
| Date of supply |   |  |  |  |
| Date GP practice notified |   |  |  |  |
| Pharmacy ODS code | F |  |  |  |  |  |
| Patient declaration overleaf to be completed |

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| --- |
| Patients who don’t have to pay must fill in parts 1 and 3. Those who pay must fill in parts 2 and 3. |
| Part 1 | The patient doesn’t have to pay because he/she: |
| [ ]  | is under **16 years** of age | Pharmacy use only Evidence not seen |
| [ ]  | is **16**, **17** or **18 and** in full-time education |
| [ ]  | is **60** years of age or over |
| [ ]  | has a valid maternity exemption certificate |
| [ ]  | has a valid medical exemption certificate |
| [ ]  | has a valid prescription pre-payment certificate |
| [ ]  | is named on a current HC2 charges certificate |
| [ ]  | is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate |
| [ ]  | or his/her partner gets Income Support |
| [ ]  | gets income-based Jobseeker’s Allowance |
| [ ]  | gets Universal Credit |
| [ ]  | gets income-related Employment and Support Allowance |
| [ ]  | or his/her partner gets Pension Credit Guarantee Credit |
| [ ]  | gets Employment and Support Allowance |
| 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 from prescription charges.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 [xxx] Clinical Commissioning Group, NHS England, the NHS Business Services Authority, the Department of Work and Pensions and Local Authorities. |
| Part 2 | I have paid | £ | Now sign and fill in Part 3. |
| Part 3 | I am the patient [ ]  the patient’s guardian [ ]  (Cross ONE box) |
| I agree that the information on this form can be shared with:* My/the patient’s GP practice to help them provide care to me/the patient
* [xxx] Clinical Commissioning Group, to allow them to make sure the service is being provided properly by the pharmacy
 |
| Signature |   | Date |  |  |  |
| If different from overleaf, add your name and address below |
| Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Address |   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  | Postcode |  |  |  |  |  |  |  |  |