Think PharmacyFirst

NHS
Newcastle Gateshead
Clinical Commissioning Group

Patient Details:

Forename:_____ D.O.B:_____ Age:

Surname :_____ Sex : M / F

Address :_____

_____ Post Code: _____

Name GP Practice:_____

Address GP Parctice:_____

Ethnicity _____ *(See Pharmoutcomes for the categories)*

Consent for Data Sharing

I am happy to share the data regarding this service with other providers of the service and the NHS for commissioning purposes. Yes ☐ No ☐

Service can not proceed without this consent

Consultation Record:

Patient is present during consultation	**Yes / No**	*If no, please state reason*
Time of Consultation		
Person Conducting Consultation & Role in Pharmacy		
Time Taken for Consultation		

Consultation Notes, Diagnosis & Products Given

Clinical Observations (presenting symptoms, history, previous treatment attempts, any examination performed etc)

Diagnosis & Products Given

v2

Service Accessibility:

Have you accessed the service before Yes ☐ No ☐

Where did you hear of the service
GP ☐ 111 ☐ Friends & Family ☐ Advert ☐ Leaflet ☐ Pharmacy ☐
Other ☐ (Please State)

If this service was not available, where would you have gone
GP ☐ 00H ☐ A&E ☐ Walk In Centre ☐ Purchase ☐
Other ☐ (Please State)

Pharmacist Details :

Name :	*Pharmacy Stamp*
GPHC No:	
Signature :	
Date:	

Don't pay – Indicate exemption category (put X mark):

A		is under 16 years of age
B		is 16 , 17 or 18 and in full time education
C		is 60 years of age or over
D		has a maternity exemption certificate
E		has a medical exemption certificate
F		has a prepayment prescription certificate
G		has a valid War Pension exemption certificate
L		is named on a current HC2 charge certificate
H		gets income support
K		gets income based job seekers allowance (JSA(1B))
M		is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
S		has a partner who gets Pension Credit guarantee credit (PCGC)

Payment – I have paid **£**

I am the: patient ☐ patient's representative ☐
child accompanied by representative ☐

Signed :_____Date: _____

Address if different from above:

_____

_____

For pharmacy use only
Cross if evidence of exemption not seen? ☐