Appendix 2

Pharmacists Prescription (FPPharm) (Revised July 2017)

Name Address Postcode DOB Male / Female NHS Number	Ethnicity: (please tick as appropriate) White - British White - Irish White - Gypsy or Irish Traveller White - Other Mixed - White and Black Caribbean Mixed - White and Black African Mixed - White and Asian Mixed - Other mixed groups Asian or Asian British - Indian Asian or Asian British - Pakistani Asian or Asian British - Bangladeshi Asian or Asian British - Chinese Asian or Asian British - Other Asian Background Black or Black British - African Black or Black British - Caribbean Black or Black British - Other Black Background Arab Any other ethnic group Prefer not to say	Surgery: Practice Name: Patient must be registered with a General Practice in NHS Hull CCG: Confirmed? **Y / N** (indicate evidence seen) ▪ Medical card ▪ Rx request sheet ▪ PMR or other pharmacy record ▪ Confirmation of registration document ▪ Surgery confirmed registration

Who referred the client **into** the Minor Ailment Service: (Tick appropriate box)

GP Practice	A&E	NHS 111	GP Practice based pharmacist
Out of hours service	Patient self-referral	Pharmacy team	Other:

Symptoms reported (condition1)	Symptoms reported (condition 2 if applicable)
Please tick one box only (condition 1) ❒ Advice and Counselling only ❒ Medicine supplied ❒ Referral to: (Please indicate) ***** GP urgent /Non-urgent ***** A&E ***** Dentist ***** Other	Please tick one box only (condition 2 if applicable): ❒ Advice and Counselling only ❒ Medicine supplied ❒ Referral to: (Please indicate) ***** GP urgent /Non-urgent ***** A&E ***** Dentist ***** Other
Medicine and quantity supplied (condition 1)	Medicine and quantity supplied (condition 2)

If this scheme was not in place where would you have gone for advice/ medication? (tick appropriate box)

GP Practice	Walk in centre	A&E	Out of Hours Service	Practice Nurse	Pharmacy purchase

Pharmacist Name (Block Capitals)	**Pharmacist signature**	**Date Supplied**

Details of this prescription will be shared with your Doctor and the Local Clinical Commissioning Group for audit purposes.
All information will be treated with the strictest confidence and held in accordance with the Data Protection Act.

Consent for sharing information received? **YES / NO**

NOTE		You will be asked to show proof that you do not have to pay prescription charges. If you do not have proof, you will still get your free medicine supply but checks will be made later to confirm your eligibility
Part 1		**The patient doesn't have to pay because he/she:**
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 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 or income related Employment and Support Allowance
K		Gets Income-based Jobseeker's 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 (PCGC).
Declaration		I declare that the information I have given on this form is correct and complete and I understand that if it is not, appropriate action may be taken against me. I confirm proper entitlement to exemption and for the purposes of checking this, I consent to the disclosure of relevant information, including to and by the Inland Revenue and Local Authorities.
Patients Signature		Patients signature to confirm exemption and receipt of medication