GREATER MANCHESTER PHARMACY CARE PLAN SERVICE

CONSENT FORM

Your Details

Full name: ____

Date of birth (DD/MM/YY): ___/___/___

Gender: Male ❒ Female ❒ Trans ❒

Address: ____

____

Postcode: ______________

Telephone number: ____________________________

GP practice address: ____

____

Do you have a carer? Yes ❒ No ❒

How did you hear about the service? Self ❒ GP ❒ Pharmacy ❒ Other ❒

Consent to participate in the Greater Manchester Pharmacy Care Plan

- I consent to participate in the Pharmacy Care Plan service*
- I confirm that the service has been explained to me
- I agree that the information obtained during the service can be shared with my doctor (GP) to help them provide care to me and
- NHS England, CPGM Healthcare Ltd, Greater Manchester LPC and the University of Manchester for the purposes of checking payments to the pharmacy and to ensure that the service is being properly provided†

* The Greater Manchester Pharmacy Care Plan team may contact you in connection with the service.
† Only anonymised data will be used for the evaluation of this service.

Full name ____________________

Signed ____________________ date ___/___/___