Bury NHS
Primary Care Trust

Chlamydia Treatment Local Enhanced Service: Client Audit Sheet

This form must accompany the invoice for transaction fees to be returned to Medicine Management team every month before the 5th of each month

Name of Pharmacy:..... Month:.....

	Date of treatment	Chlamydia reference number (CRN)	Name, strength & quantity of drug issued	Drug taken on premises ? Y/N	Was a pregnancy test carried out /supplied? Y/N	If treatment was not issued, please state reason	Time Taken for consultation	Name of Accredited Pharmacist who undertook consultation
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10								
11								