ENROLMENT FORM

- ☐ **Pentasa tablets**
- ☐ **Pentasa sachets**
- ☐ **Pentasa enema**
- ☐ **Pentasa suppository**

Patient Details:

Stick a copy of the bag label here

COMPLETE THIS FORM CLEARLY AND LEGIBLY USING BLOCK CAPITALS. (*mandatory fields must be completed)

Step 1

*OCS Code (F Code)

☐ ☐ ☐ ☐ ☐

Step 2

*Patient's title: .....

*Patient's name: .....

*Patient's address: .....

.....

.....

*Patient's postcode: .....

*Patient's tel no: .....
(Necessary for nurse support)

Patient's mobile no: .....
(If you wish to receive a daily text reminder to take your medicine)

Patient's email address: .....

Patient's date of birth: .....

Step 3

*Patient / Carer / Pharmacist signature:
(Delete as appropriate)

.....

If carer or pharmacist, please print name in capitals:

.....

*Date: .....

Step 4

Patient: Hand form back to Pharmacy Team.

Pharmacy Team: Fax to **0115 837 9854.**

I have been informed about Pentasa Support and I give my consent to being enrolled and contacted by Wizzard Limited (an independent management company) on behalf of Ferring Ltd by email, text, telephone or by letter.

By signing this form I agree that the personal information I have provided to you will be held on a central database by Wizzard Limited. Any information provided by you will be solely for the purpose of PS membership only and will not be divulged to third parties.

Personal Data will be processed in accordance with the Data Protection Act 1998. Subject to exceptions, you will have the right to make a subject access request regarding your information and request that your information is ameded or deleted.

NOTE TO PHARMACIST: PLEASE FAX TO (0115 837 9854)

FERRING PHARMACEUTICALS

Created and provided as a free educational support item by Ferring Ltd.
Strictly for use by patients on Pentasa (Mesalazine)

PA/780/2014/UK May 2014