

Referral from Community Pharmacy

Patient's name:.....

Patient's D.O.B:.....

Patient's address:.....

.....

The patient named above has accessed the Pharmacy First Scheme for Treatment of Impetigo/Simple UTI and following assessment by the pharmacist on duty a referral has been recommended based on the following information;

Pharmacist's
comments:.....

.....

.....

Indication of urgency (please tick):

- Accident and Emergency
- Contact GP or other HCP within 24 hours
- Contact GP or other HCP within days if symptoms do not resolve

Pharmacist's name (PRINT).....

Pharmacy telephone
number.....

Pharmacy address.....

.....

Date and time.....

Pharmacist signature.....

Please ensure that this form is given to your GP or other Healthcare Professional