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 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