**Appendix 1:**

**PHARMACY AGREEMENT**

**CLIENT NAME: DOB:**

**Purpose**

This is a formal agreement between the Service User, Prescriber, Recovery Worker and Pharmacy. The purpose of this agreement is to ensure all parties are clear on their responsibilities and to ensure adherence to the national framework of Clinical Governance.

**Responsibilities:**

**Service User**

* To notify Prescriber/Recovery Worker and the Pharmacist of any changes to personal circumstances.
* To adhere to the guidance list below.
* To engage with Prescribing Service and the Pharmacy.
* To be responsible for own medication and only take as directed.
* To not display any violent, aggressive or abusive behaviour to any party involved in providing treatment.

**Prescriber/Recovery Worker**

* To act or respond to any reasonable request within a suitable timeframe.
* To ensure Service User dignity, privacy and respect wherever possible.
* To engage and support the Service User as appropriate.
* To openly discuss any concerns with the Service User and Pharmacy.

**Pharmacy**

* To provide the service as described.
* To provide a service and suitable environment that ensures dignity, privacy and respect wherever possible.
* To engage and support the Service User as appropriate.
* To openly discuss any concerns with the Service User and Prescriber/Recovery Worker.
* To report any concerns to Prescribing Service without delay.

1. My prescription will be decided by my Prescriber, Recovery Worker and me.

2. When attending the pharmacy for the first time

* I will be expected to show some form of identification.
* If my prescription is for ‘supervised consumption’ I will be asked where in the pharmacy I would like to consume my medication.

 I also need to be prepared to show some form of identification at any time.

3. I will attend the named pharmacy in person, at the time arranged by the Pharmacist and myself.

4. The Pharmacist, Prescribing Service and Recovery Worker have the right to refuse to see me and will not dispense my medication if they believe I am intoxicated.

5. All parties involved in this treatment plan will be treated with respect and dignity at all times.

6. I understand that I can only obtain prescriptions for my medication from the Prescribing Service named in this contract. I cannot have my medication dispensed by another pharmacy without negotiating this with my Recovery Worker first.

 Any changes required due to work or holiday arrangements will need to be negotiated with my Recovery Worker, with at least 14 days notice.

7. I am responsible for all drugs prescribed to me and, if I should lose them or take them other than as directed, they will not be replaced.

8. I understand that I must collect my medication on the specified days. If I am unable to collect my medication I need to notify my Recovery Worker who will advise the Pharmacy. I understand that no-one else can collect my medication unless pre-arranged with my Recovery Worker.

9. It is my responsibility to keep my medication in a safe, locked place and out of reach of children.

10. I understand that if I do not collect my medication for:

* **three or more consecutive days** if I am on daily pick up or
* if I miss a pick up resulting in **three missed doses**
* if I miss an **increasing/titrating** dose

the pharmacy will not dispense my medication until my treatment has been re-assessed. If this happens the Pharmacist will contact the Prescribing Service and I will need to contact my Recovery Worker to have my treatment reviewed.

The Pharmacist will also advise my Recovery Worker if I regularly miss collecting on the specified days.

11. I agree to see my Recovery Worker and Prescriber regularly and will keep all appointments, unless by prior arrangement. If I do not attend appointments my treatment will be reviewed and may be suspended.

12. All persons involved in my treatment are expected to provide this service as discreetly as possible.

13. I understand that information will need to be shared between all those involved in my treatment as outlined below:

* + Recovery Worker.
	+ Prescriber.
	+ Pharmacist.

14. I understand that agencies involved in my treatment will not share information and knowledge about me without my permission. I understand there are a few exceptional circumstances where agencies involved in my treatment would disclose information to an outside agency without my consent:

* If it is believed that the welfare and safety of children and/or young people under 18 and/or welfare of vulnerable adults are being put at risk
* If I express intent to harm myself or agencies involved in my treatment have any concerns about my immediate welfare
* If I express an intent to harm or cause injury to a third party
* If the service is instructed by a court of law to reveal information about me

I understand that under normal circumstances, written consent will be obtained from me before the information is disclosed. I understand that no information will be shared with family or friends without my consent.

This agreement will commence on: …………………………………….…………………..

[Prescribing Service to enter start date]

* I will attend the pharmacy named below, at a pre-arranged time if appropriate.

(Pharmacist to state appropriate time) ………………………………………………

* I have read, and agree to this agreement

|  |  |  |
| --- | --- | --- |
| **SERVICE****USER** | **NAME:****ADDRESS:****PHONE NUMBER:** | **SIGNATURE &****DATE** |
|  |
| **PRESCRIBER** | **NAME:****ADDRESS:** **PHONE NUMBER:** |  |
| **RECOVERY****WORKER** | **NAME:****ADDRESS:****PHONE NUMBER:** |  |
| **PHARMACIST** | **NAME:****ADDRESS:** **PHONE NUMBER:** |  |

 Recovery Worker to ensure that copies go to:

* Pharmacy
* Service User (if requested)
* G.P. (if Service User is in GP Shared Care)

 Original to go into Service User notes