



Pharmacy Nominated Pick-up Request Form

Patient name:	
Patient address:	
Date of Birth:	

Dear Pharmacist,

The above GMMH patient is currently in self isolation due to Covid-19. The patient has informed us that they wish to nominate the following person to collect the prescription on their behalf:

Name:	
Relationship to Patient:	

Many thanks

Signed: Date:
(GMMH Treatment Team)

For Pharmacists:

Letter received by (pharmacist name)	
Registration number:	
Date received:	

For nominated representative to complete on collection of prescription:

Name of Nominated Person:	
Signature:	
Date of prescription collection:	