All aspects of this form must be filled in for audit purposes

MK PharmacyFirst

NHS Bedfordshire, Luton and Milton Keynes Clinical Commissioning Group

FPPharm (Pharmacists Prescription)

Please ensure that patients have signed the declaration overleaf

Patient's Name…….. DOB ……

Address ……

……

Surgery ……

……..

Pharmacy Stamp

Patient's Presenting Symptoms: (Please tick)

Athlete's Foot		**Bacterial Conjunctivitis**		**Constipation**		**Contact Dermatitis**	
Cough		**Cystitis**		**Diarrhoea**		**Ear Wax build up**	
Fever		**Hay Fever / Allergies**		**Insect Bites or Stings**		**Mouth Ulcers**	
Pain incl. Headache		**Nappy Rash**		**Nasal Congestion**		**Oral Thrush**	
Sore Throat		**Teething**		**Threadworm**		**Vaginal Thrush**	
						Warts & Verrucae	

Details of formulary items supplied:

Bazuka Gel (5g)		Loratadine 5mg/5ml oral solution (100ml)	
Beclometasone Nasal Spray (180)		Loratadine Tablets 10mg (30)	
Bonjela Gel (15g)		Mebendazole 100mg Chewable Tablet (1)	
Cetirizine Tablets 10mg (30)		Miconazole 2% Cream (30g)	
Cetirizine 1mg/1ml oral solution SF (200ml)		Miconazole 2% Oral Gel SF (15g)	
Chloramphenicol 0.5% Eye Drops (10ml)		Paracetamol Soluble 500mg Tablets (24)	
Chloramphenicol 1% Eye Ointment (4g)		Paracetamol Susp SF 120 mg / 5 ml (100 ml)	
Chlorhexidine Mouthwash (300ml)		Paracetamol Susp SF 250 mg / 5 ml (100 ml)	
Chlorphenamine Syrup (150 ml)		Pholcodine Linctus SF 5mg/5ml (200ml)	
Chlorphenamine Tablets 4 mg (30)		Potassium Citrate Sachets (6)	
Clotrimazole Cream 1% (20g)		Rehydration Sachets (6)	
Clotrimazole Cream 2% (20g)		Senna Tablets 7.5mg (20)	
Clotrimazole Combi 2% 500mg		Sodium Bicarbonate 5% Ear Drops (10ml)	
Clotrimazole Pessary (500 mg)		Sodium Chloride Nasal Drops (10ml)	
Dentinox Teething Gel (15g)		Sudocrem (125g)	
Fluconazole 150mg capsule (1)		Xylometazoline 0.05% Nasal Drops	
Guaphenesin SF syrup 66.67mg/5ml (150ml)		Xylometazoline 0.1% Nasal Spray	
Hydrocortisone Cream 1% (15g)		Sodium Cromoglicate Eye Drops (10 ml)	
Ibuprofen Susp 100 mg/5 ml (100 ml)		Zeroderm Ointment (125g)	
Ispaghula Husk Sachets (10)			

Please tick √

Self-care advice given (see protocol)		**Signposted to other sources of advice e.g. www.nhs.uk**	

Pharmacist's Signature:

Date:

Retain this in the pharmacy for 18 months as evidence of activity.

An electronic version is available on request from: Sharon.wilmore@nhs.net

June 2020

All aspects of this form must be filled in for audit purposes

DECLARATION OF EXEMPTION

The patient doesn't have to pay because he/she:

A	☐	**is under 16 years of age**
B	☐	**is 16, 17 or 18 and in full-time education**
C	☐	**is named on a current HC2 charges certificate**
D	☐	*** gets Income Support or income-related Employment and Support Allowance**
E	☐	*** gets income-based Jobseekers Allowance**
F	☐	*** is entitled to, or named on, a valid NHS Tax Credit exemption certificate**
G	☐	*** gets Pension Credit Guarantees Credit (PGGC)**

* Name of person who gets benefit * DoB * NI no.

Evidence of Exemption Seen: YES ☐ NO ☐

To the Patient: Please complete declaration below and answer the following questions – this is important to help us evaluate the service:-

I have received the above medicine(s) and am exempt from charges for the reason specified above.

Signed ……..…. Date……..

I am the patient ☐ I am the patient's representative ☐ (Please tick one)

If you had not used this minor ailments scheme would you have …?

a)	**consulted the GP**	☐
b)	**visited the Urgent Care Service**	☐
c)	**gone to A&E**	☐
d)	**bought the medicine from the pharmacy**	☐
e)	**managed without**	☐
f)	**other (please specify)**	**…….**

Please rate this service 1-5 (1 being poor 5 being excellent) …….

Have you used this scheme before? Yes/No

Please indicate if you would **not** like us to contact you regarding a short questionnaire on the service you have received ☐

IMPORTANT – Your Pharmacist is providing treatment and/or advice under the Minor Ailments Scheme in line with the symptoms you have described. If your symptoms persist you should seek further advice from your doctor. Please advise the doctor which pharmacy you have attended and what advice and/or treatment you have already received from the Pharmacist.

CLAIM **Date submitted to CCG:**

To assist calculation of monthly claim, complete this table at the time of issue. Then total the forms at month end. Alternatively the pharmacy may use the monthly calculator and keep a running tally.

(Item 1	£	)	Total cost of items supplied	£
(Item 2	£	)	Professional fee	£
(Item 3	£	)	Total	£

N.B. Only claim one fee per patient