|  |  |  |
| --- | --- | --- |
| **Notification of intent to provide**  **Appliance Use Reviews (AURs)** | No. of sheets of documentary evidence attached: |  |

*Form to be submitted to the local NHS England team by a pharmacy contractor prior to provision of AURs.*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **To:** | | | | | | | |
| *Name of AT:* | | | | | | | |
| **Pharmacy details** | | | | | | | |
| *Contractor name:* | | | | *Trading name (if different)* | | *ODS code (F code):* | |
| *Address:* | | | | | | *Telephone Number:* | |
| **Persons to carry out AUR** | | | | | | | |
| *Full Name:* | *Role:* | | *Education, training or experience in respect of the use of specified appliances (NB documentary evidence needs to be submitted with this form):* | | | *Details of relevant clinical training and practice in respect of the use of specified appliances:* | |
| *Full Name:* | *Role:* | | *Education, training or experience in respect of the use of specified appliances (NB documentary evidence needs to be submitted with this form):* | | | *Details of relevant clinical training and practice in respect of the use of specified appliances:* | |
| *Full Name:* | *Role:* | | *Education, training or experience in respect of the use of specified appliances (NB documentary evidence needs to be submitted with this form):* | | | *Details of relevant clinical training and practice in respect of the use of specified appliances:* | |
| **Location** | | | | | | | |
| I/we intend to carry out AURs:  *(tick the box for all options that apply)* | | | At the above pharmacy | | | At patients’ homes  *.* | |
| **Declaration** | | | | | | | |
| I / we confirm that the pharmacy:   * Is complying with the Terms of Service relating to the provision of Essential Services; * Has an acceptable system of clinical governance; * Has procedures in place to ensure referral of patients to the prescriber of the appliance in any case where a matter relating to a patient’s use of an appliance arises in the course of an AUR, but falls outside the scope of the service; and * Undertakes to provide the AURs from      . *(insert date)*   I / we confirm that the premises contain a consultation area which meets the requirements specified in The Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013. *(Only applicable where AUR services are to be provided at the pharmacy)* | | | | | | | |
| *Signature:* | | *Name:* | | | *Position:* | | *Date:* |
| *Contact for queries relating to this form (if different from above):* | | | | | *Telephone number:* | | |