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| **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.*

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| **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:*      |