**Avon LPC Dementia Friendly Pharmacy Project.**

**Please sign and date this declaration. Keep a copy for yourself and return a copy to Avon LPC by post to:**

Avon Dementia Friendly Pharmacy Project, 14A High Street, Staple Hill, Bristol BS16 5HP.

**Via E-mail to:**

dementia.avonlpc@gmail.com

Pharmacy Name…………………………………………………………………………………………………

Pharmacy Address ……………......………………………………………………………………………… …………………………………………………….……………………………………………………………………

E-mail…………………………………………………………………………………………………………………

Telephone………………………………………………………………………………………………………….

Premises:

Has suitable consultation room (MUR approved) Yes/No

Personnel:

Pharmacist Name……………………………………………………………………………………………..

GPhC Number……………………………………………………………………………………………………

Dementia Focal Point Training date completed…………………………….……………………

Dementia Awareness Session Date…………………………………………………………………….

Pharmacist Name……………………………………………………………………………………………..

GPhC Number……………………………………………………………………………………………………

Dementia Focal Point Training date completed…………………………….……………………

Dementia Awareness Session Date…………………………………………………………………….

Pharmacy Technician or Assistants that attended dementia awareness session.

Name……………………………………………………….Date attended………………………

Name……………………………………………………….Date attended………………………

Name……………………………………………………….Date attended………………………

Name……………………………………………………….Date attended………………………

Name……………………………………………………….Date attended………………………

Range of Customer Information Leaflets Available Yes/No

Local Signposting Resources Yes/No

Relevant Poster and leaflet displayed. Yes/No

Window Sticker Displayed. Yes/No

PharmOutcomes available and activated. Yes/No

GP Briefing Done. By Letter By Meeting. Not Done Yet.

I confirm that I have read and agree to the terms and conditions in the Avon Dementia Friendly Pharmacy Service Specification.

Signature.

Name.

Job title.