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| Part A: Patient details: To be completed by the patient/patients’ representative | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Title: | | | | First Name: | | | | | | | | | | | | Surname: | | | | | | | | |
| Address:  Postcode: Telephone number: | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of birth: | | | | | | Gender: Male 🞎  Female 🞎 | | | | | | | | GP Practice:  GP Name: | | | | | | | | | | |
| How did you hear about the service? | | | | | | | | | | | | | | | | | | | | | | | | |
| Previous user | | | 🞎 | | | Pharmacy poster/leaflet | | | | | | | | | | | | 🞎 | | NHS website | | | 🞎 | |
| Pharmacy staff | | | 🞎 | | | GP poster/leaflet | | | | | | | | | | | | 🞎 | | Social media | | | 🞎 | |
| Friends/family | | | 🞎 | | | Advised by a healthcare professional | | | | | | | | | | | | 🞎 | |  | | |  | |
| Other - Please state: | | | | | | | | | | | | | | | | | |  | |  | | |  | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Part B: Consultation details: To be completed by the Pharmacy | | | | | | | | | | | | | | | | | | | | | | | | |
| Pharmacy (Stamp): | | | | | | | | | | Pharmacist Name: | | | | | | | Date of Consultation:  Time of Consultation: | | | | | | | |
| If the patient had not come to the Minor Ailments Service, where would they have gone: | | | | | | | | | | | | | | | | | | | | | | | | |
| Self-care only | | | | 🞎 | | | GP Practice | | | | | 🞎 | | | Out of Hours | | | | | | | 🞎 | | |
| A&E | | | | 🞎 | | | NHS 111 | | | | | 🞎 | | | Other – Please State: | | | | | | |  | | |
| Presenting condition:  🞎 Conjunctivits (superficial eye infection)  🞎 Urinary tract infection in women  🞎 Impetigo  🞎 Nipple thrush in breastfeeding women  🞎 Oral thrush in infants | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| Medicine(s) dispensed? Yes 🞎 No 🞎 | | | | | | | | | | | | | | | | | | | | | | | | |
| If yes, please state  Name of medicine(s) from the formulary: | | | | | | | | | | | | | Quantity: | | | | | | | | | | | |
| Manufacturer:  Batch number:  Expiry date: | | | | | | | | | | | | | | | | | | | | | | | | |
| If first line option wasn’t provided please give reason: | | | | | | | | | | | | | | | | | | | | | | | | |
| If no medicine was dispensed please give the reason: | | | | | | | | | | | | | | | | | | | | | | | | |
| Required counselling only | | | | | | 🞎 | | | Referred to other healthcare professional | | | | | | | | | | | 🞎 | OTC purchase | | | 🞎 |
| Other – Please state: | | | | | |  | | |  | | | | | | | | | |  | |  | | |  |
| Did the Pharmacy refer the patient on? Yes 🞎 No 🞎 | | | | | | | | | | | | | | | | | | | | | | | | |
| GP | 🞎 | Out of Hours | | | 🞎 | | | A&E | | | 🞎 | Other – Please state: | | | | | | | | | | | | |
| Reason for onward referral:  Patient did not meet the inclusion criteria for the presenting condition 🞎  Other – Please state: | | | | | | | | | | | | | | | | | | | | | | | | |
| Is the patient exempt from NHS prescription charges? Yes 🞎 No 🞎 | | | | | | | | | | | | | | | | | | | | | | | | |

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| Part C: Prescription Declaration  Patients who pay for their prescriptions must fill in Part 1and sign and date below  Patients who do not pay for their prescriptions must fill in Parts 2 and sign and date below   |  | | --- | | Part 1  If you paid enter the amount  £ | |
|  |
| |  | | --- | | Part 2  A is 60 years of age or over or is under 16 years of age  B is 16,17 or 18 and in full time education  D Maternity exemption certificate  E Medical exemption certificate  F Prescription prepayment certificate  G Prescription exemption certificate issued by Ministry of Defence  L HC2 (full help) certificate  H Income support or Income-related Employment and Support Allowance  K Income based Jobseekers Allowance  M Tax Credit exemption certificate  S Pension Credit Guarantee Credit (including partners)  U Universal Credit and meets the criteria. Find out more at [www.nhsbsa.nhs.uk/UC](http://www.nhsbsa.nhs.uk/UC) | |
| Part 2: Data Protection and Confidentiality |
| I am the patient 🞎 I am the patient’s representative 🞎 |
| Information recorded at this Minor Ailments Service consultation will be made available to:   * PharmOutcomes\* for service payment and audit purposes * Cheshire Clinical Commissioning Groupfor audit purposes\*\* (Anonymously) * Your (or the patient’s) GP may be informed of your (or the patient’s) Minor Ailments Service consultation as necessary and with consent   Personal data will be held in accordance with the provisions and principles of the Data Protection Act 2018.  \**PharmOutcomes is an external company employed by NHS Cheshire Clinical Commissioning Group to process consultation information. PharmOutcomes may view details of your consultation for the purposes of financial administration and audit.*  \*\**Cheshire Clinical Commissioning Group is an NHS organisation that commissions the Minor Ailments Service for their population*  I consent to information about my (or the patient’s) consultation being process in the manner detailed above: Yes 🞎 No 🞎  I consent to information about my (or the patient’s) consultation, including any medicine supplied being shared with my GP: Yes 🞎 No 🞎 |
| Signature Date |
| B: No medication has been issued to me on this occasion 🞎 |