Pharmacy stamp

NHS WALES PHARMACEUTICAL SERVICES – ADVANCED SERVICES
PATIENT CONSENT FORM

CONSENT TO PARTICIPATE (tick one)**:**

The NHS Medicines Use Review/Prescription Intervention Service ☐

The NHS Discharge Medicines Review Service ☐

The NHS Appliance Use Review Service ☐

Patient Name: _____

Patient Address: _____

_____

Postcode: _____

I agree that the information obtained during the service can be shared with:

- My doctor (GP) to help them provide me with care ☐
- The Local Health Board (LHB) to help them to make sure the service is being provided appropriately and to help them plan future services ☐
- The Local Health Board (LHB) and the NHS Wales Shared Services Partnership to make sure that the pharmacy is being paid appropriately for the services provided. ☐

CONSENT FOR ANOTHER PERSON TO PARTICIPATE IN THE NHS DISCHARGE MEDICINES REVIEW SERVICE ON MY BEHALF:

I agree that the pharmacists may discuss information regarding the medicines and/or appliances I am prescribed and how I take them with:

Name: _____

Acting in their capacity as:

- My carer ☐
- My named representative ☐

I understand that:

- I may withdraw my consent at any time, time at which my participation in the NHS Discharge Medicines Review Service will end. ☐

CONSENT FOR TO PARTICIPATE IN THE NHS DISCHARGE MEDICINES REVIEW SERVICE PROVIDED BY A PARENT OR GUARDIAN:

I confirm that:

- I am participating in the NHS Discharge Medicines Review Service on behalf of a minor, in my capacity as his or her parent or legal guardian. ☐

I understand that:

- I may withdraw my consent at any time, time at which my participation in the NHS Discharge Medicines Review Service will end. ☐

DECLARATION

Patient Signature: _____

Date: _____

This form is to be retained by the pharmacy