NHS North Tyneside CCG
NHS Northumberland CCG

Patient's Name ____

Address ____

Postcode _____________ DOB ________________

NHS Number: ____________________ Male ☐ Female ☐

GP Practice __________________________

Patient's Presenting Symptoms: (Please tick)					
Bites/ Stings		Ear Wax		Post-imms pyrexia	
Chicken Pox		Eczema / Dermatitis		Teething	
Cold sores		Fungal Skin		Threadworms	
Conjunctivitis		Haemorrhoids		Thrush, Genital	
Constipation		Hay fever		Thrush, Oral	
Colic		Head Lice		URTI (coughs/ colds)	
Cystitis in women		Mouth Ulcers		Warts/ Verrucae	
Diarrhoea		Muscular aches&pains			
Dyspepsia		Nappy Rash			

Treatments supplied:

Advice Provided:

Was the patient referred? Yes / No
If yes, where: GP within 24 hours GP non-urgent A&E Dentist
Other:

If the service were not available, what would the patient have done?
GP A&E Nothing Purchased WIC OOH Other:

How did the patient hear about the service?
Word of mouth Poster in pharmacy Poster in GP practice
Newspaper Pharmacy staff Practice staff Other:

Pharmacy use only
Evidence of exemption not seen but requested: ☐

Exemption Declaration
The patient/ parent does not have to pay because: (delete as applicable)

	You are 16, 17 or 18 and in full-time education. **Under 16's not automatically eligible unless parent is exempt.**
	You are 60 years of age or over.
	You are named on a current HC2 charges certificate.*
	You get or are included in an award of someone getting income support, or income related employment and support allowance.*
	You get or are included in an award of someone getting income based jobseekers allowance **(Incapacity Benefit or Disability Living Allowance do not count, as they are not income related).***
	You are entitled to, or named on, a valid NHS tax credit exemption Certificate.*
	Has a partner in receipt of Pension Credit guarantee credit*

*Name of person in receipt of benefit: ______________________________

DOB _______________ NI No _______________

I declare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by, the NHS Business Services Authority, the Department of Work and Pensions, CCGs, NECS and other providers.

I am: the patient ☐ patient's representative ☐

Signature ____________________ Date ___________

Pharmacist's signature ____________________

Name ____________________

GPhC no ____________ Date __________

Version 1

Pharmacy Stamp