**Referral Form for Additional Medicines Management Support in a Care Home**

*Please complete this form fully to help determine nature of support required and ensure pharmacy resources are used effectively.*

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| **Referrer details:** | Date: Click here to enter a date. |
| Name: | Job role: |
| Contact email: | Contact telephone: |
| **Care Home details:** | Name: | Postcode: |
| Type of care home: Choose an item. |
| Bed capacity (if known):  |
| Telephone Number:  | Fax Number: *(if known)* |
| Key contact and job role: |
| **GP Practice (main GP under CHES) details:***See page 2 if more than one GP practice* | Name: | Postcode: |
| GP lead for care home: | Contact details: |
| **Pharmacist support in GP practice** *– if known* | Name(s): | Contact details: |

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| **Reason for referral.** |

Please email your referral to glccg.pharm.carehomeglos@nhs.net

Does the practice provide care to all the patients in the home? Yes / No

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| If more than one GP practice involved please complete below details if known: |
| **GP Practice - 2 details:** | Name: | Postcode: |
| GP lead for care home: | Contact details: |
| **GP Practice - 3 details:** | Name: | Postcode: |
| GP lead for care home: | Contact details: |

***FOR OFFICE USE ONLY***

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| *Other factors to help determine level of priority required:*  |
| *CHST information*  |  |
| *Prescribing data* |  |
| *Other:**e.g. Medication safety concerns / CQC report / Hospital admission/discharge data* |  |

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| Lead Pharmacist assigned to Care Home |  |