MEDICOS PHARMACY

# E.T.P. Nomination Form

Forest Hill Pharmacy, 197 Stanstead Rd, London SE23 1HU

Tel/Fax: 020 8690 6060

**Personal details:**

Full Name: _____

NHS Number: _____ Date of Birth: _____

Full address: _____

Telephone: _____ Mobile: _____

Email: _____

**Surgery Information:**

Doctor's name: _____

Surgery name: _____

Surgery address: _____

☐ **I authorise Forest Hill Pharmacy to order my medication on contact from myself or my representative and collect my prescription from my surgery. I will inform the Pharmacy if I wish to make changes to this arrangement.**

☐ **I would like Forest Hill Pharmacy to keep my repeat slip to order my medication automatically at the required interval and collect my prescription from my surgery. I will inform the Pharmacy if I wish to make changes to this arrangement.**

☐ **I would like Forest Hill Pharmacy to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Forest Hill Pharmacy if I wish to make changes to this arrangement.**

**Are you the patient or the patient's representative providing these consents?**

☐ **Patient**

☐ **Representative** (please note that by signing below you confirm that you are authorised to act on behalf of the patient and to give consent to the use of information as described in this form)

- **Representative's full name:** _____

- **Relationship to patient:** _____

**Signature:** _____ **Date:** _____