

Please tick if URGENT

Patients requiring support to order their medicines referral form

From Pharmacy	
To Surgery	
Patient name:	
Patient DOB:	
Address:	

I have assessed the above patient and feel they require support to enable them to order their regular medication in a safe manner for the following reasons.

	Tick
1. Patients receiving support as part of the Barnsley Medication Management Scheme (i.e. not all MDS patients).	
2. Patients without reliable family or carer support and <ol style="list-style-type: none">Unable to physically access reordering pathways (speech, hearing difficulties, ability to access online forms)Experiencing sufficient cognitive impairment (may be identified by social services or via MUR) e.g. dementia, memory loss, experiencing difficulty with orientation in timeSignificant language barriers that can only resolved by<ol style="list-style-type: none">A <i>third party to act a translator</i>A <i>third party managing orders after initial support from a translator</i>	<ol style="list-style-type: none">a)b)c)<ol style="list-style-type: none">i.ii.
3. Patients with limited mental impairment where removal of third party ordering risks continuity of care e.g. extreme anxiety when handling change, or unable to access methods of reordering	
4. Patients transitioning from a 'cared for environment' (e.g. hospital stay, custodial sentence, care/residential home)	
5. Patients where their caring responsibilities limit their capacity to manage their own medication, and that of the patient being cared for	
6. Patients where there are safeguarding concerns related to their self-management of medication	
Supporting Information (required)	

This is:

An ongoing need	Due review after (date)
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Assessment carried out by:

Name:	Signed:
Date:	
Contact details:	

Practice note: Once accepted please read code on the practice system as community pharmacy ordering patient. EMIS: 66RD System1: XaaYT