

Chew Medical Practice

PATIENT CONSENT FORM

The services listed below are designed to make the process of receiving your medicines easier. Once we have received your completed and signed consent form we will be able to deliver your prescriptions for you.

(The consent form must be signed either by the patient or their representative.)

Name	
Address	
Post Code	
Telephone Number	
e.mail address (optional)	

Please place a tick in the box against the relevant box(es):

<input type="checkbox"/>	I request and give permission for the prescription delivery service offered by Chew Medical Practice to deliver dispensed medicines to my home.
<input type="checkbox"/>	To order repeat prescriptions I will complete & return the repeat slip to the delivery driver or contact the surgery either telephone, e.mail or fax or by leaving the repeat slip for my prescription at the surgery, Madam's Paddock.
<input type="checkbox"/>	I accept responsibility for being available at the time of the medication delivery to my home. I will be advised of when the delivery is due to take place

In the event that I am not able to sign for my medication I would like my dispensed medication to be

<input type="checkbox"/>	Returned to the Surgery and delivery re-arranged, or
<input type="checkbox"/>	Posted through the letter-box/other. Please specify

(The Practice will not be held responsible or liable for any damage caused to the medication if this option is requested. It is the patient's duty of care to ensure that the medication will not be delivered to a location accessible by unsupervised children or pets who may tamper with the packaging.)

I will inform you if I wish to make any changes to this agreement.

Signed **Date**/...../..... **OR**

<input type="checkbox"/>	I am the representative of the above person and have been authorised to sign on their behalf.
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Print Name **Signature**

Official use only	Maria	List	EMIS MA	MAP
	DOB	Reg No.	Eligibility	