# Application for Care Leavers’ Prescription Support

**This application is for Care Leavers who are not already eligible for Free NHS Prescriptions**

Please complete this document and submit via email to: [cichealthteam@ghc.nhs.uk](mailto:cichealthteam@ghc.nhs.uk) with subject line ‘Care Leaver Prescription Request’.

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| **Your Personal Details** | | | | |
| First Name |  | | | |
| Last Name |  | | | |
| Date of Birth (DOB) |  | | | |
| Address (*current*) |  | | Post Code | |
| Email Address |  | | | |
| Telephone Number |  | | | |
| NHS Number (if known) |  | | | |
| **Details of your GP Surgery** | | | | |
| General Practitioner (GP) |  | | | |
| General Practitioner (GP)  Address |  | | Post Code | |
| **Details of Personal Advisor / Leaving Care Worker** | | | | |
| Name of Personal Advisor / Leaving Care Worker |  | | | |
| Personal Advisor / Leaving Care Worker  Telephone Number (if known) |  | | | |
| Personal Advisor / Leaving Care Worker  Email Address |  | | | |
| Leaving Care Team |  | | | |
| **Details of request** | | | | |
| If the help you need relates to any of the below, the team of qualified healthcare professionals at your local pharmacy can offer clinical advice to manage minor health concerns safely and effectively rather than visiting your GP:   |  |  |  | | --- | --- | --- | | Allergies and Hayfever  Coughs, colds and nasal congestion  Ear-related condition  Insect bites and stings  Haemorrhoids  Mouth-related condition  Tooth related condition | Cradle Cap  Headaches and infrequent migraines  Eye-related condition  Indigestion and heartburn  Urinary-related condition  Skin-related condition  Vitamins and Minerals | Constipation and diarrhoea  Minor pain and discomfort  Foot-related condition  Headlice  Minor burns and scalds  Throat-related condition |   By visiting your pharmacy to purchase this medication you will have a faster service and will be supporting our NHS services to give priority to treatment of more serious conditions, such as cancer, diabetes and mental health problems. | | | | |
| What is your application for? | | One-off prescription  3 months – Pre-Payment Certificate  12 months – Pre-Payment Certificate | | |
| Have you already collected and paid for your prescription? | | Yes  No  N/A – don’t currently have a prescription to be filled but I am requesting a pre-payment certificate ahead of my next prescription | | |
| You are not required to answer the questions below to receive the support you need. However, this information would be useful for our evaluation of this scheme. | | | | |
| Are you intending to use a pre-payment prescription to purchase items for health concerns listed above which can be purchased in your local pharmacy? | | Yes | | No |
| If yes, please tell us which health concern(s) you are looking to seek support for | |  | | |
| Do you have a long-term health condition or disability? | | Yes | | No |
| Do you have an ongoing health need that will require prescriptions for more than 3 months? | | Yes | | No |

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| **I consent to NHS Gloucestershire using my personal details to check eligibility of my application and for monitoring purposes** | | |
| Name: | Signature: | Date: |

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| *For completion by NHS Gloucestershire*: **Approval of request** | |
| Is the young person eligible for free prescriptions? | Yes  No |
| Approval period agreed | One-off prescription  3 months – Pre-Payment Certificate  12 months – Pre-Payment Certificate |
| Name of Approver (on behalf of NHS Gloucestershire)………………………………………………………………………  Signed………………………………………………………………………………………………………………………………  Date………………………………………………………………………………………………………………………………… | |
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