**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](mailto:glccg.pharm.carehomeglos@nhs.net)

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

|  |  |  |
| --- | --- | --- |
| 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 |  |