Gluten-Free Food Service

Patient Registration Form

GPs please complete and sign this part of the form and allow patients to take it to the pharmacy of their choice.

Patient's full name	
Patient's CHI	**Male/Female**
Address **Postcode**	**Patient's GP/Surgery**
Patient's contact telephone no. and/or e mail address	
Condition Coeliac Disease/Dermatitis Herpetiformis	**Carer Details (if appropriate)**

The above patient should receive the following GFFS units per month.....(in figures) .....(in words). Please see Coeliac UK recommended allocated units (http://www.coeliac.org.uk).

I have/have not (please delete) given prescriptions for one months supply of products. I will no longer supply GFF for this patient from ...../...../..... (date).

GP's signature .....Date.....

GP name .....Prescriber No.....

Pharmacists please complete and sign this part of the form.

Registration	
Patient Medication Record (PMR) completed Yes/No	**Name and address of Pharmacy**
Pharmacy Coeliac Annual Assessment required Yes/No	

Pharmacist's declaration I declare that the information I have given on this form is correct and complete.

Pharmacist's signature ..... Date .....

Contractor's Code ..... Pharmacy Stamp

Patients please complete and sign this part of the form. I agree to obtain my gluten-free foods from the above pharmacy as detailed.

Patient's signature .....Date.....