Please complete all relevant sections of form as much as possible and forward to patient’s regular community pharmacist

#### National Compliance Assessment Package (NCAP)

##### Multi-agency Referral Form

**Patient name**: DOB:

Address:

Telephone: CHI Number:

Lives alone- Yes/No circle) House bound- Yes/No (circle)

**Informal Carer input** (if applicable):

Relationship to patient: Telephone:

### Contact address (if different from above): \_\_\_\_\_\_\_\_\_\_\_\_

Community Pharmacist:

Address:

Telephone number: FAX number:

## Social Care/professional carer input (if applicable): Designation

Address:

Telephone: Visit frequency daily or times per week (*circle)*\_\_\_\_\_

## General practitioner:

Address:

Telephone number: FAX number:

# Referral details

Patient referred by Contact number Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relevant Medical History** **Circle as appropriate**

Stroke, arthritis, high blood pressure, cataract, glaucoma or history of falls/fractures

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication:**

 If available please attach GP repeat medication slip/ computer print/medication chart or complete table below including non-prescription medicines.

|  |  |  |  |
| --- | --- | --- | --- |
| Name of medication | Form | Dose | Times of administration |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

# Reason for assessment: Circle as appropriate

1. Is patient taking their medication as prescribed? Yes No
2. Does the patient understand why they are taking medication? Yes No
3. Patient has difficulty opening bottles/foil pack? Yes No
4. Patient has difficulties with ordering repeat medication? Yes No
5. Patient can not read labels/ patient information leaflets Yes No
6. Is the patient confused or forgetful? Yes No

Comments

The Pharmacist assessor will contact patient / carer to arrange an appointment and will inform you of the result of the assessment.

National Compliance Assessment Package (NCAP)

National Compliance Assessment Package (NCAP)

**NCAP Needs Assessment Patient Consent**

**A. To be completed before the assessment**

I understand the purpose of this assessment and I agree/do not agree to participate.

**I consent**/**do not consent** **to the sharing of information amongst agencies**

# Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed**

**Date**

B. To be completed after the assessment

I agree / do not agree with the outcome of the assessment

# Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signed**

Date