Community Pharmacy Serial Prescription Patient Nomination Form

Please complete the details below and submit to the patient's GP practice for consideration to switching the patient to a serial prescription.

Community Pharmacy Name and address (or Pharmacy stamp)

Patient Name -

CHI -

GP practice -

Patient is registered for MCR – Yes/ No*	No
All repeat items are suitable for Serial Rx - Yes/ No*	No
Patient is receiving regular acute items - Yes/ No*	No
Known issues with medication compliance – Yes/ No*	No
Approximate due date for next prescription-	
Patient counselled on serial prescribing – Yes/ No*	No

If no for any of the above, please add notes here:

*please select as appropriate