Community Pharmacy Nutrition Support Service
Registration Form

NHS Greater Glasgow and Clyde

Patient details		**GP details**
Name		
CHI		
Address		
Postcode		
Tel no		
Guardian/Carer details if appropriate		
Registration date		

The above patient has agreed to participate in the Community Pharmacy Nutrition Support Service, through which pharmacies offer advice and support to patients who are at risk of or who have established malnutrition.

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

Pharmacist's name and signature		Date	
Pharmacy Stamp		Contractor Code	

Patient / Carer please complete and sign this part of the form

I agree / I agree on behalf of the patient above to participate in the Community Pharmacy Nutrition Support Service and understand that as part of this relevant clinical information with regards to my / the patient's nutritional treatment will be shared between professionals involved in this service e.g. Dietitian, Community Pharmacy staff, Carers and GPs. I also understand that my information will be used to help develop service improvements.

I also agree to attend this pharmacy for the duration of my / the patient's nutritional treatment plan.

I consent to being contacted in future for evaluation purposes: YES ☐ NO ☐

Patient / Carer's Signature		Date	
Print name			