**Tayside Community Pharmacy Palliative Care Network**

**Contact Recording Form**

Name of Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR Pharmacy stamp

Pharmacist’s name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Day/Date/Time** | **Medication name, strength and formulation** | **Priority** | **Who initiated request** | **Activity** | **Time taken** |
| e.g. Mon 21 July at 4.45 pm |  | 1. Urgent (5 – 10 mins)2. Today3. Within 24 hours4. Over 24 hours5. Other (please specify) | 1. Patient2. Carer3. Health care  professional4. Other (please specify) | 1. Supply2. Advice3. Choice of therapy4. Referral5. Other (please specify) | 1. 0 – 10 mins2. 10 – 30 mins3. 30 mins – 1 hour4. Over 1 hour5. Other |
| 1. |  |  |  |  |  |
| 2. |  |  |  |  |  |
| 3. |  |  |  |  |  |
| 4. |  |  |  |  |  |
| 5. |  |  |  |  |  |
| 6. |  |  |  |  |  |

This form should be submitted (detailing August activity) by 7th September 2022 to Diane Robertson, Community Pharmacy Development Manager, East Day Home, Kings Cross, Clepington Road, Dundee or emailed to diane.robertson9@nhs.scot