# Appendix 1:

**Patient Registration – MAR Provision**

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| --- | --- |
| Patient Name   | DOB  |
| GP Practice *(name and phone number)*  |
| Care Provider *(name and phone number)*  |
| Times of Care Provider visits *(if known)*  |
| Who is ordering medication? |   |
| Who is collecting/delivering medication?  |   |
| How is ‘when required’ medication to be managed (specifically who will order and what directions will be required)?    |
| Date service started (mm/yy)  |
| Any other information: |

*This form should be retained in the pharmacy (in either paper or electronic form) and be supplied to NHS Grampian upon request.*