**Monthly Audit and Claim Form for Community Pharmacy Activity**

Month/Year of Consultation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contractor Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **Buprenorphine/Suboxone Supervision** | No of clients | No of doses observed |  |
|  |  |  |  |
| **Needle exchange** | No of clients | Estimated no of syringes/needles received | Number of One-hit kits supplied |
|  |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Pharmacist Name | Signature | | Date |
|  |  | |  |
| Health board use only | |  | |
| Name | | Date added to Board Input spreadsheet | |
|  | |  | |

NB: Individual contractors may be asked to provide evidence of providing the service.

Please submit to [shet.pharmacyprimarycare@nhs.scot](mailto:shet.pharmacyprimarycare@nhs.scot) by the 5th of each month