**Level C Patient Information Form**

(To be completed for all new Level C Patients)

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| **Patient Details:**  Name:  ………………………………...  Address:  ………………………………...  ………………………………...  CHI Number:  ………………………………...  Age:  ………………………………... | **Care Provider Details:**  (*must be completed*)  Name of Agency:  ………………………………...  Office Telephone Number:  ………………………………...  Other contact details  (e.g. Manager)  ………………………………...  ………………………………... | | **Initial Chart Produced and supplied by:**  This Pharmacy  DGRI  Community Hospital |
|  |
| **Complete only if appropriate**  Following assessment of need by the Healthcare/Social Care Team, it has been recommended that medication is dispensed on a weekly basis, in normal containers, due to identified risks………………  Weekly dispensing has been agreed by the patient’s GP…………………………………………………. | | | |
| **Medication Issues** identified during medication review | | | |
| **Additional Information for the GP** | | | |
| **Patient’s GP Details:**  Name of GP: …………………………………….......................  Practice: ……………………………………...…………..  Telephone Number:……………………………………... | | **Pharmacy Details:**  Name of Pharmacy:……………………………………..  Address………………………………………………………..  …………………………………………………………………….  Contractor Code:………………. Tel No:…………………………. | |

**FOR RECORDS – 3 COPIES TO BE MADE**

* **1 copy for to be retained in the Community Pharmacy**
* **1 copy to be submitted to the GP for the patient**
* **1 copy to be sent to PCD with monthly returns**