**Community Pharmacy Palliative Care Network**

**Quarterly Claim Form**

**Pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contractor Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* I have ensured that all staff working within the pharmacy (including locums) are aware that the pharmacy is participating in the community pharmacy palliative care network
* I have maintained the agreed stock of palliative care medicines as per formulary
* I have reviewed medications with the patient/carer, provided advice and information and contacted other healthcare professionals when a need has been identified
* I intend to continue to provide this service
* I claim the professional fee to be paid to the contractor for providing this service.

Q1 (April - June) Submit end of June

Q2 (July - Sept) Submit end of Sept

Q3 (Oct - Dec) Submit end of Dec

Q4 (Jan - Mar) Submit end of March

 **Please return the completed form by fax or email by the end of each quarter month, to:** Ewa.Kargul@lanarkshire.scot.nhs.uk & Dominic.Hughes@lanarkshire.scot.nhs.uk