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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ***[Template]*Homecare Medicine Service: Patient Registration Form** | | | | | | | | | | | | | | | | | | | | | | |
| **Homecare Provider:** | | | |  | | | | | | **Therapy Area / Service:** | | | | |  | | | | | | | |
| PATIENT, CARER and GP DETAILS | | | | | | | | | | | | NHS number: | | | | | |  | | | | |
| Hospital number: | | | | | |  | | | | | | Diagnosis: | | | | | |  | | | | |
| Title |  | | Forename: | | |  | | | | | |  | | | | | |  | | | | |
|  |  | | Surname: | | |  | | | | | | Clinical lead name: | | | | | |  | | | | |
| Date of birth: | | | | | |  | | | | | | Clinical lead phone: | | | | | |  | | | | |
| Address: *(Address label can be affixed here)* | | | | | |  | | | | | | Clinical specialist name: | | | | | |  | | | | |
|  | | | | | |  | | | | | | Clinical specialist phone: | | | | | |  | | | | |
|  | | | | | |  | | | | | | Clinical pharmacist name: | | | | | |  | | | | |
| Postcode: | | | | | |  | | | | | | Clinical pharmacist phone: | | | | | |  | | | | |
| Gender: | | | | | | Male  Female  | | | | | | GP name: | | | | | |  | | | | |
| Preferred phone: | | | | | |  | | | | | | GP surgery: | | | | | |  | | | | |
| Alternative phone: | | | | | |  | | | | | | Parent/carer name: | | | | | |  | | | | |
| OK to leave a message? | | | | | | Yes  No  | | | | | | Relationship to patient: | | | | | |  | | | | |
| Email address: | | | | | |  | | | | | | Parent/carer phone: | | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| SERVICE REQUIREMENTS – Low Tech and Delivery Service Module | | | | | | | | | | | | | | | | | | | | | | |
| Registration status | | | | | | | New patient  Switch provider  Switch therapy  | | | | | | | | | | | | | | | |
| Initial delivery / treatment details | | | | | | | | | | | Delivery may be received by: | | | | | | Anyone at delivery address  Specified Person(s) | | | | |    |
| Delivery Address: *(If different from home address)* | | | | | | |  | | | |  | | | | | |  | | | | |  |
|  | | | | | | |  | | | | Specified person(s):- *Name, phone, relationship to patient* | | | | | |  | | | | | |
| Postcode: | | | | | | |  | | | |  | | | | | |  | | | | | |
| 1st delivery required by: | | | | | | |  | | | |  | | | | | |  | | | | | |
| Initial delivery frequency: | | | | | | | [4 Weekly  8 Weekly  12 Weekly] Other  Please specify: | | | | | | | | | | | | | | | |
| Patient individual Care Plan (PICP) attached *If yes give reference and/or date* | | | | | | | | | | | Yes  No  | | | PICP Ref: | |  | | | | | | |
| ADDITIONAL CLINICAL SERVICE REQUIREMENTS – Mid Tech Module *[Optional section–amend/remove as required]* | | | | | | | | | | | | | | | | | | | | | | |
| Patient administration training required: | | | | | | | | Yes  No  | | | If yes, required by date: | | | | | | | |  | | | |
| Patient administration training to be provided by: | | | | | | | | Hospital Nurse Community Nurse  Homecare Provider   Other  Please specify: | | | | | | | | | | | | | | |
| ADDITIONAL CLINICAL SERVICE REQUIREMENTS – High Tech Module *[Optional section–amend/remove as required]* | | | | | | | | | | | | | | | | | | | | | | |
| Nurse administration required: | | | | | | | | Yes  No  | | | If yes, 1st visit required by date: | | | | | | | |  | | | |
| Nurse administration to be provided by: | | | | | | | | Hospital Nurse  Community Nurse  Homecare Provider   Other  Please specify: | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| REFERRING PHYSICIAN/HEALTHCARE PROFESSIONAL | | | | | | | | | | | | | | | | | | | | | | |
| ⮚ I have discussed and provided sufficient information about the Homecare service to the above named patient and the patient has agreed to the referral into the homecare service ⮚ I confirm that an appropriate home suitability assessment has been completed and that the patient is suitable for the homecare service ⮚I confirm I have informed the patient that this homecare service may be funded by a pharmaceutical company | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | |  | | | | | | | Name:  *(please print)* | | | |  | | | | | | | Date: |  | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| INVOICING DETAILS & ADMINISTRATIVE CONTACTS | | | | | | | | | | | | | | | | | | | | | | |
| Invoice address: *(If different from hospital address)* | | | | |  | | | | | | Invoice Contact name: | | | | | |  | | | | | |
|  | | | | |  | | | | | | Contact phone number: | | | | | |  | | | | | |
|  | | | | |  | | | | | | Contact email address: | | | | | |  | | | | | |
| Postcode: | | | | |  | | | | | | Invoice account name: | | | | | |  | | | | | |
| Homecare lead name: | | | | |  | | | | | | Homecare lead phone: | | | | | |  | | | | | |
| Email address: *(for repeat prescriptions requests)* | | | | | | | | | | |  | | | | | | | | | | | |