|  |
| --- |
| ***[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)*   |       |