# Homecare Medicines Service: Patient Registration Form and Patient Consent Form Templates

## Introduction & Scope

The Patient Registration Form and Patient Consent Form templates are updated versions of the combined patient registration and consent form template published in the Royal Pharmaceutical Society Handbook for Homecare Services in England[[1]](#footnote-1) in May 2014.

The templates are intended for use across all homecare medicines services; including those funded by manufacturers (Medicines Authorisation Holders).

The key aims are to:

* reduce unnecessary variation of registration and consent forms in use across the homecare market;
* Enable streamlined switching of patients between homecare providers;
* Minimise the risk of transcription or interpretation error;
* Ensure key data fields are captured in line with current guidance.

## Implementation

These templates are suitable for use without adaptation for most homecare medicines services. There are clearly identified optional sections and editable fields *(See section below)* which may be reviewed and adapted for each therapy / service - other sections of the form should not be changed. The minimum level of adaptation necessary to meet the therapy / service requirement should be undertaken.

## Pre-population and editable fields / sections

There are number of optional sections and editable fields in the templates which should be reviewed prior to use.

The optional sections are:

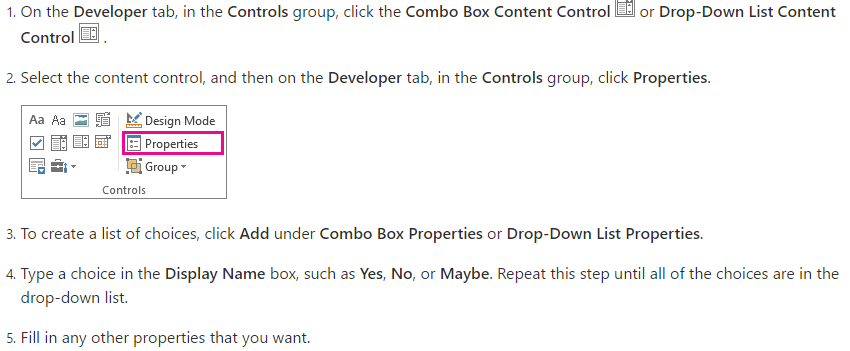
* Mid tech service section
* High tech service section
* Patient support programme opt-out – for manufacturer’s patient support programmes
* Administrative management sections

Editable fields are:

* Hospital logo, name, street, town, city, postcode.
* Initial delivery frequency

Many fields on the Patient Registration and Patient Consent forms could be pre-populated locally either at therapy area / service level or at a patient level using locally established links to an electronic patient record.

There are three drop down boxes in the Patient Registration Form: “Homecare Provider”, “Therapy Area / Service” and “Title”. These can be edited to suit local requirements. Below is an extract from a Microsoft support page for editing combo box controls - <https://support.office.com/en-us/article/Edit-templates-b2cb7adb-aec2-429f-81fd-3d5bd33cf264#__toc359169126>



A referring centre may choose to enhance more of the fields with drop down boxes to assist completion of the form.

## Consent

Unless agreed otherwise in the contract, the referring centre is responsible for gaining appropriate consent from the patient2 and sharing this with the homecare provider.

The Patient Consent form is intended to act as a single consent for the homecare service meaning the patient2 should not be required to provide further consent directly to the homecare provider for provision of standard services as outlined in the contract. Some enhanced services may require additional specific consent: such services are most commonly found in manufacturer’s (Medicines Authorisation Holder) patient support programmes.

The Patient Consent Form should usually be completed at the same time as the Patient Registration Form; this ensures written consent from the patient[[2]](#footnote-2) is captured prior to any patient data being transferred to the homecare provider.

Where, for any reason, the Patient Consent Form is not completed at the same time as the Patient Registration form, verbal consent from the patient2 for their patient data to be shared with the homecare provider must be sought by the referrer to allow appropriate progression of the registration process. The healthcare professional who signs the registration form is responsible for ensuring this has been given. This consent must be captured in the clinical referral section of the registration form if the full patient consent is not completed by the patient. Full written or verbal consent from the patient2 should be sought at the earliest opportunity and shared with the homecare provider.

## Registration and Consent form templates – Embedded Document

A copy of the registration and consent form templates without the guidance notes are embedded below to avoid formatting issues when removing content from the document.  


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| ***[Template]*Homecare 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 as per therapy pathway or remove if not applicable]* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 as per therapy pathway or remove if not applicable]* | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 the Homecare service with the above named patient and provided sufficient information to allow provision of informed consent and the patient has agreed to the homecare service.   I confirm that an appropriate home suitability assessment has been completed and I agree that the patient is suitable for the homecare service. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Signature: | | | |  | | | | | | | Name:  *(please print)* | | | | |  | | | | | | | | Date: |  | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| INVOICING DETAILS & ADMINSTRTIVE 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)* | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| ***[Template]*Homecare Service - Patient Consent Form** | | | | | | | | | | | | | | | | | | | | | | | | | |
| PATIENT CONSENT | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient name: | |  | | | | | | | | | | Patient hospital/NHS number: | | | | | | | | |  | | | | | | |
|  I authorise the hospital’s chosen homecare provider and any other subcontracted parties, to hold and use my personal information for the purpose of providing the Homecare Service. My personal information to be shared may include my name, address, date of birth, current/past medications and medical history and any other information relevant to the provision of the service.  I understand it is my responsibility to ensure I have the consent of other individuals before sharing their personal information with the hospital or homecare provider e.g. carer’s contact details.  When holding and using my personal data and the personal data of other individuals given by me, all organisations will be required by the hospital to comply with the Data Protection Act 1998 and the prevailing NHS Information Governance standards.  I understand I have the right to ask which organisations hold and use my personal information and I may request access to the data and request this information to be corrected if errors are found. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I authorise my homecare prescriptions to be sent directly to the hospital’s chosen homecare provider and for them to supply me with medicines and associated items requested by the hospital. Where needed, I authorise the hospital’s chosen homecare company to request repeat prescriptions on my behalf from my prescriber. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I understand that the hospital may change the chosen homecare provider with appropriate notification to me. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I understand that I can withdraw from the homecare service at any time. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I understand that I must still attend my regular hospital and G.P. appointments so that my health is monitored effectively and the hospital can ensure the treatment and homecare service provided is appropriate for me. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I understand that all deliveries must be signed for by an adult and I may be contacted to verify the homecare services provided to me. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I agree to occasional contact to obtain feedback on my satisfaction with the service. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I accept that if I am not able to or do not comply with the service requirement or choose not to share my personal data with the organisations providing the homecare service, I will be withdrawn from the homecare service. If I am withdrawn from the homecare service the hospital will make reasonable efforts to find an alternative treatment solution for me and/or refer me back to my G.P for reassessment of my needs. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  I have discussed and understood the homecare service to be provided by the hospital’s chosen Homecare Provider and I have given my full consent for the Homecare Service. | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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| PATIENT SUPPORT PROGRAMME OPT-OUT:  *[Optional section – remove if not applicable. Usually pharma funded services only]* | |
|  I understand that I will be sent information about additional patient support programmes available alongside this homecare service. If I subsequently choose to enrol onto a patient support programme, my personal information will be shared with the organisation(s) providing the patient support programme. I have the right to opt-out of patient support programme(s) at any time. | |
| I **do not** wish to receive information about additional patient support programmes available alongside this homecare service? |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Patient Signature: |  | Print name: |  | Date: |  |
| If not signed by patient, state relationship to patient: | |  | | | |

**[Optional sections]**

FOR PHARMACY DEPT OFFICE USE ONLY

|  |  |  |  |
| --- | --- | --- | --- |
| Patient name: |  | Patient hospital/NHS number: |  |
| Clinical Referrer: |  | Date Registration Form  signed by clinical referrer: |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| REGISTRATION FORM APPROVED BY | | | | | | | | |
| Patient individual Care Plan (PICP) updated and attached  *If yes give reference and/or date* | | | Yes  No | | PICP Ref: | | | |
| Prescription attached | | | | | | Yes  No | | |
| Service request within SLA/Contract terms   *If No, additional costs may be incurred, if required, request costs from HCP before approval* | | | | | | Yes  No | | |
| Purchase Order attached | | | | | | Yes  No | | |
| Comments- | | | | | | | | |
| Signature: |  | Name:  *(please print)* | |  | | | Date |  |
| APPROVED CHANGE REQUST SENT TO  HOMECARE PROVIDER BY | | HCP Name: | | | | | | |
| Signature: |  | Name:  *(please print)* | |  | | | Date& Time: |  |

FOR HOMECARE PROVIDER USE ONLY

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **PATIENT REGISTRATION ACCEPTED BY HOMECARE PROVIDER (HCP)** | | | | | | |
| Additional cost to Purchasing Authority outside contract / SLA *if yes give details* | | | | Yes  No | | |
| Comments:- | | | | | | |
| Homecare Provider  Signature: |  | Name:  *(please print)* |  | | Date/ Time: |  |

1. Royal Pharmaceutical Society Handbook for Homecare Services. <http://www.rpharms.com/support-pdfs/homecare-services-handbook.pdf> [↑](#footnote-ref-1)
2. The term “patient” in this section can include the patient’s legal guardian or legal representative as appropriate. [↑](#footnote-ref-2)