

# E.T.P Nomination Form

Grafton Pharmacy. 132-132a Tottenham Court Road, London, W1T5AZ  
Tel/Fax: 020 7383 4233

## **Personal details:**

Full name: \_\_\_\_\_

Full address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

## **Surgery Information:**

Doctor's name: \_\_\_\_\_

Surgery name: \_\_\_\_\_

Surgery address: \_\_\_\_\_

- I would like Grafton Pharmacy to keep my repeat slip to order my medication on contact from myself or representative and collect either in person or by means of electronic transfer my prescription from my surgery. I will inform Grafton Pharmacy if I wish to make changes to this arrangement.
- I would like Grafton Pharmacy to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Grafton Pharmacy if I wish to make changes to this arrangement.

## **Are you the patient or the patient's representative providing these consents?**

- Patient
- Representative** (please note that by signing below you confirm that you are authorised to act on behalf of the patient and to give consent to the use of information as described in this form)

- Representative's full name: \_\_\_\_\_

- Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_