E.T.P Nomination Form

Sandylight Pharmacy. 131 Queens Crescent, Kentish Town, London, NW5 4EG
Tel/Fax: 020 7267 1138

Personal details:

Full Name: _____

NHS Number: _____ Date of Birth: _____

Full address: _____

Telephone: _____ Mobile: _____

Email: _____

Surgery Information:

Doctor's name: _____

Surgery name: _____

Surgery address: _____

☐ **I authorise Sandylight Pharmacy to order my medication on contact from myself or my representative and collect my prescription from my surgery. I will inform the Pharmacy if I wish to make changes to this arrangement.**

☐ **I would like Sandylight Pharmacy to keep my repeat slip to order my medication automatically at the required interval and collect my prescription from my surgery. I will inform the Pharmacy if I wish to make changes to this arrangement.**

☐ **I would like Sandylight Pharmacy to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Sandylight 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:** _____