

# E.T.P Nomination Form

Desons Pharmacy. 216 Harrow View, Harrow, Middlesex, HA2 6PL.  
Tel: 020 8723 0858

## 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 Desons 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 Desons 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 Desons Pharmacy to collect, either in person or by means of electronic transfer, my prescription from my surgery. I will inform Desons 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: \_\_\_\_\_