

# E.T.P Nomination Form

Finstead Pharmacy. 193 Hoxton Street, London N1 6RA.  
Tel: 020 7729 6151

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