E.T.P Nomination Form

Finstead Pharmacy. 193 Hoxton Street, London, N1 6RA
Tel: 020 7729 6151 Fax: 020 7729 5663

Personal details:

Full name: ____

Full address: ____

Telephone: _______________________ Mobile: _______________________

Email: ____

Surgery Information:

Doctor's name: ____

Surgery name: ____

Surgery address: ____

☐ **I would like Finstead 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 Finstead 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:** ________________