NHS
Dudley
Clinical Commissioning Group

Pharmaceutical Public Health Team,
Dudley CCG, 2nd Floor,
Brierley Hill Health and Social Centre,
Venture Way, Brierley Hill
West Midlands
DY5 1RU
Tel No: 01384 321979

Primary Care Referral form for a Medication Review

1. This service provides a comprehensive clinical medication review (to assess the appropriateness, effectiveness and safety of medication) by a Practice Based Pharmacist or Older Persons Specialist Pharmacist
2. Please complete the form below and e-mail to dudley.medman@nhs.net for the attention of: Pharmaceutical Public Health Team.
3. Has the patient consented to a medication review (verbal or written) and is this documented in their records?: Yes ☐ No ☐
4. If available, please attach a current medication list (including allergies), a medical history summary and any specialist assessments and observations.
5. If you are a patient who is self – referring please complete just the 'Patient Information' section below
6. Patients will be seen in order of the date the referral is received but please ring 01384 321979 to check availability if a more urgent review is required.
7. Acknowledgement of referral: The aim is to respond to all requests within 48 hours of receipt (emails: by direct reply to the nhs.net account and by a phone call if it is a fax referral).

   If you are a patient and do not have access to and email/fax please phone the above number (between 9am and 4pm) and a member of the Medicines Management team will be able to help you.

Patient Information

Name	
Address	
Date of Birth	
Telephone number	
Preferred language	
Any relevant additional information: e.g. visual or hearing impairment, translator needed?	
Is a domiciliary (home) visit required?	**YES/ NO** (delete as appropriate)
Name of patients' GP	
Address of patients' GP	
Is this a self-referral?	**YES / NO** (delete as appropriate**)**

Details of the Referrer

Name of Referrer		What is your relationship to the patient	
Phone number		Have you obtained patients' consent?	**Yes/ No**
E-mail address		Date of referral	
Reason for referral		Other relevant comments	

For office use only: Received by: …… Date: …… Date Pharmacist informed: ……