FORM CP2(SS)(5) NATIONAL HEALTH SERVICE (SCOTLAND)

Name

Address

Age if under 12 yrs.

Yrs / Mths

Postcode

Pharmacy Stamp

DOB/CHI No.

Male

Female

Dispensing Pack Sizes

Registration

Withdrawal

Pack Sizes *Numbers only*

Pack Sizes *Numbers only*

Declaration: "I accept the above named patient into the Minor Ailment Service and have registered them under the contracted terms and conditions of that service."

Signature of Pharmacist

Date

Consultation Only

Refer to GP

PS Contractor Code

RPSGB Reg Number

Please read notes overleaf and complete relevant parts

01820182

FORM CP3(SS)(5) NATIONAL HEALTH SERVICE (SCOTLAND)

Name

Address

Age if under 12 yrs.

Yrs / Mths

Postcode

Pharmacy Stamp

DOB/CHI No.

Male

Female

CMS Registration Declaration

Registration

I hereby accept the patient named above into the Chronic Medication Service at this NHS community pharmacy under the terms and conditions of the relevant NHS Pharmaceutical Services Regulations and Directions. I consent to any relevant checks on the claims I make in respect of this service being undertaken by the Common Services Agency.

CMS Withdrawal Declaration

Withdrawal

I hereby withdraw the patient named above from the list of patients registered for the Chronic Medication Service at this NHS community pharmacy.

Signature of Pharmacist

Date

PS Contractor Code

RPSGB Reg Number

Please read notes overleaf and complete relevant parts

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CP3(SS)(5) IMPORTANT NOTES FOR PATIENTS

CMS Registration Declaration

A: Consent for Data Sharing

☐ I consent to any necessary and relevant dispensing and clinical data about my care under the NHS Chronic Medication Service (CMS) being shared between my community pharmacy and GP practice.

B: CMS Registration

☐ I wish to access NHS pharmaceutical services under the NHS Chronic Medication Service (CMS) from this NHS community pharmacy and I understand and accept the conditions which apply to this registration for CMS, as explained by the pharmacist.

C: CMS Eligibility

☐ I confirm that:
i) I am registered as a patient with a GP Practice in Scotland other than as a temporary resident; and
ii) I have a long term condition(s) which requires ongoing management.

D: CMS Declaration

☐ I consent to any relevant clinical data about my care under CMS which is necessary and relevant to the prevention, detection and investigation of crime being shared between my pharmacy, GP Practice and the Common Services Agency.

☐ I declare that the information I have given on this form is correct and complete. I understand that, if it is not, appropriate action may be taken. I consent to the disclosure of relevant information from this form including to and by the Common Services Agency, my GP Practice and my community pharmacy to enable the Agency to confirm my eligibility to register for CMS and for the purposes of prevention, detection and investigation of crime. I also consent to the disclosure of any relevant data to the Agency for the purposes of prevention, detection and investigation of contractor fraud.

{Please cross one box below and then sign and date the form}

☐ I am the patient.

☐ I am the patient's representative

Sign here _____ Date / /

CMS Withdrawal Declaration

☐ I hereby withdraw my registration for the NHS Chronic Medication Service at this community pharmacy.

{Please cross one box below and then sign and date the form}

☐ I am the patient.

☐ I am the patient's representative

Sign here _____ Date / /

CP2(SS)(5)

IMPORTANT NOTES FOR PATIENTS

- This form records that your pharmacist has supplied you with medicine free of charge, and/or offered you professional advice at your request.
- Fill in parts A and B below in black ballpoint pen.

PART A The patient doesn't have to pay because he/she: (X in the appropriate box)

A ☐	is under 16 years of age
B ☐	is 16,17 or 18 years of age and in full time education
C ☐	is 60 years of age or over
D ☐	has a valid maternity or medical exemption certificate (EC92)
F ☐	has a valid War Pension exemption certificate
K ☐	is named on a current NHS HC2 certificate
G ☐	*gets, or has a partner who gets Income Support
H ☐	*has a partner who gets 'Pension Credit **guarantee credit**' (PCGC)
I ☐	*gets, or has a partner who gets, **income based** Jobseeker's Allowance
J ☐	*is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
M ☐	*gets, or has a partner who gets, **income related** Employment Support Allowance

Pharmacy Use Only ☐ Evidence Not Seen

*Name	Date of Birth	NI no.

*I am included in an award of income based Jobseeker's Allowance, income related Employment and Support Allowance, Income Support, Pension Credit Guarantee Credit or Tax Credit. Print the name of the person who gets the benefit.

PART B **Declaration for patients who do not have to pay**

"I declare that the information I have given on this form is correct and complete. I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption/remission. To enable the NHS to check I have a valid exemption/remission and for the purposes of prevention, detection and investigation of crime, I consent to the disclosure of relevant information from this form including to and by the Common Services Agency, the NHS Business Services Authority, the Department for Work and Pensions, HM Revenue and Customs and Local Authorities. I agree to pay the cost of the prescription if I am later found not to be entitled. In addition, a statutory penalty may be payable."

Cross ONE box: I am the patient ☐ patient's representative ☐

Now sign below

Sign here _____ Date / /

Print name & address *if different from overleaf*