NHS Appliance Use Review Service Record Form

CONFIDENTIAL

Pharmacy details

Pharmacy name:	*Name of pharmacist ☐ or specialist nurse ☐:*
Address:	*Telephone Number:*
	Date of AUR:

Patient details

Name:	*NHS Number:*	*Name of GP/Practice:*
Address:	*Date of birth:*	*GP Practice address:*

Patient consent

I consent to undertake an NHS Appliance Use Review provided by the pharmacy named above.

I agree that:

- A copy of this form will be retained by the pharmacy;
- My registered General Practitioner may be informed about the review and where necessary a copy of this form will be sent to him/her;
- Any nurse, employed by the Clinical Commissioning Group, who provides me with care may be informed about the review and where necessary a copy of this form will be sent to him/her

Patient's signature:	*Date:*	*Date AUR requested or agreed to by patient (if different):*

Reason for review

Location of AUR

Pharmacy ☐ Patient's home ☐

Other people present

Name of other people present at AUR and their relationship with the patient:

Details of appliances used by the patient

Product description:

Issues identified during the AUR and advice given to the patient:

Product description:

Issues identified during the AUR and advice given to the patient:

Product description:

Issues identified during the AUR and advice given to the patient:

Product description:

Issues identified during the AUR and advice given to the patient:

Other notes

This record must be retained by the pharmacy contractor for a minimum period of 12 months or such longer time period as the PCT may reasonably require.

☐ Entry noting provision of the AUR made on patient's pharmacy record.