

CALDERDALE

HEAD LICE SERVICE CONSULTATION FORM

(Please retain at the pharmacy for 3-months for audit purposes)



Details

Date: ____ / ____ / ____

Family Postcode: ____ / ____

Family Surname _____

Pharmacy Code: F _____

Initial Counselling

Only 'X' the boxes below if the patient(s) present(s) to the pharmacy with no evidence of infection. Marking this box will indicate that **NO** drug treatment has been provided.

Initial Counselling & Advice Given _____

Head lice Comb Supplied _____

Patient Declaration

I have received information on head lice, how to check for current infection and how to access the pharmacy head lice service.

Patient / Representative's signature: _____

Date ____ / ____ / ____

Supply of Treatment

Total number of head lice samples reviewed: _____

Number of patients with confirmed head lice: _____

Products supplied (Indicate the quantity of each product supplied under a FP10 exemption or FP10 charge paid in the boxes below. Products supplied OTC must **not** be included in this section).

Derbac M Liquid 50ml: ____ Hedrin Lotion 50ml: ____ Wet combing method: ____

Derbac M Liquid 200ml: ____ Hedrin Lotion 150ml: ____

Pharmacist Declaration

(Must be signed by the accredited pharmacist)

I certify that the patient(s) does(do) not have to pay for this treatment.

I certify that I am named in the Local Enhanced Service (LES) authorisation agreement and that I have carried out the duties as stated in the LES

Signed (pharmacist): _____

GPhC Number: ____ _ / ____ _ / ____ _

Date: ____ / ____ / ____

DECLARATION OF EXEMPTION

NOTE - You **will** be asked to show proof that you do not have to pay prescription charges, such as a benefit book or exemption certificate.

The patient does not have to pay because he/she:

- | | | |
|----------|--------------------------|---|
| A | <input type="checkbox"/> | Is under 16 years of age |
| B | <input type="checkbox"/> | Is 16, 17 or 18 and in full time education |
| C | <input type="checkbox"/> | Is 60 years of age or over |
| D | <input type="checkbox"/> | Has a valid maternity exemption certificate |
| E | <input type="checkbox"/> | Has a valid medical exemption certificate |
| F | <input type="checkbox"/> | Has a valid prescription pre-payment plan |
| G | <input type="checkbox"/> | Has a valid War Pension exemption certificate |
| H | <input type="checkbox"/> | Gets Income Support or income-related Employment and Support Allowance |
| K | <input type="checkbox"/> | Gets income based Jobseeker's Allowance |
| L | <input type="checkbox"/> | Is named on a current HC2 charges certificate |
| M | <input type="checkbox"/> | Is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate |
| N | <input type="checkbox"/> | Has paid the current FP10 charge |
| S | <input type="checkbox"/> | Has a partner who gets Pension Credit Guarantee Credit (PCGC) |

Patient Declaration

(To be completed or on behalf of **ALL** patients)

Where appropriate, I have received information about head lice infection, detection combing and how to access the Community Pharmacy Head Lice Service.

Exemption declaration. I declare that the information I have given on this form is correct and complete and I understand that if it is not, appropriate action may be taken. I confirm proper entitlement to exemption. To enable NHS England to check I have a valid exemption and to help prevent and detect fraud, I consent to the disclosure of relevant information on this form to appropriate NHS and governmental bodies.

Patient / Representative's signature: _____

Date: ____ / ____ / ____