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	☐	Is under 16 years of age
B	☐	Is 16, 17 or 18 **and** in full time education
C	☐	Is 60 years of age or over
D	☐	Has a valid maternity exemption certificate
E	☐	Has a valid medical exemption certificate
F	☐	Has a valid prescription pre-payment plan
G	☐	Has a valid War Pension exemption certificate
H	☐	Gets Income Support or income-related Employment and Support Allowance
K	☐	Gets **income based** Jobseeker's Allowance
L	☐	Is named on a current HC2 charges certificate
M	☐	Is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
N	☐	Has paid the current FP10 charge
S	☐	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: ____ / ____ / ____