Minor Ailment Consultation form
To be retained at the pharmacy for audit purposes

Pharmacy Stamp

Pharmacy Code F ☐☐☐☐

Patient name _____

Patient postcode _____

Date of birth _____

GP Practice _____

Presenting Minor Ailment - tick all that apply							
Cold Sores		Earache		Indigestion/Heartburn		Nappy Rash	
Constipation		Earwax		Insect bite or Sting		Sore Throat	
Cough		Fungal Infection		Minor self-limiting pain		Temperature	
Dermatitis		Hay Fever		Mouth Ulcers		Threadworm	
Diarrhoea		Headache		Nasal Congestion		Thrush	
				Other (please specify)			

Action by Pharmacist (Please tick as appropriate)

Advice (and information leaflet if applicable) ☐

Treatment and advice
(and information leaflet if applicable) ☐

Referral to GP ☐

Please list medicines supplied as included on the formulary:

IMPORTANT – Your Pharmacist is providing treatment and / or advice under the Minor Ailments Service in line with the symptoms you have described. If your symptoms persist you should seek further advice from your doctor. Please advise the doctor which pharmacy you have attended and what advice and / or treatment you have already received from the Pharmacist.

To be completed by the Pharmacist: The above patient was accepted onto the Minor Ailments Service and was provided with advice, information leaflets and treatment as detailed above.

Signed (Pharmacist)……

GPhC number……,…… **Date** ……

To be completed by the Patient:

☐ I confirm that NO medicine has been issued but I have received advice (and, if applicable, printed information on self-care regarding the minor ailment)

☐ I have been supplied with …..… number of medicines, without charge, the medication on this prescription and completed the declaration on the reverse of this form

Signed (Patient)…… **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 doesn't 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
- **L** ☐ Is named on a current HC2 charges certificate
- **X** ☐ Was prescribed free-of-charge contraceptives
- **H** ☐ Gets Income Support (IS)*
- **K** ☐ Gets **income based** Jobseeker's Allowance (JSA (IB))*
- **M** ☐ Is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate*
- **S** ☐ Has a partner who gets Pension Credit guarantee credit (PCGC)*

***Give details of the person getting benefit, this may be your partner.**

Name _____ **Date of birth** _____

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 the NHS to check I have a valid exemption and to prevent and detect fraud and incorrectness, I consent to the disclosure of relevant information from this form to and by the NHS Business Services, the NHS Counter Fraud and Security Management Service, the Department for Work and Pensions and Local Authorities.

I am the patient ☐ **I am the patient's parent / guardian** ☐

Sign here…….. **Date……**

Evidence of Exemption Seen: **YES** **NO**

Penalty Charges If you are found to have made a wrongful claim and free prescriptions, you will face charges and may be prosecuted under powers introduced by the Health Act 1999. Routine checks are carried out on exemption claims including some where proof may have been shown. You may be contacted in the course of such checks.