**Pharmacy First**

**Referral Feedback report from**

**(Pharmacy Name) to (Practice Name)**

**Month Overview**

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| --- | --- |
| **End of (Month)** | |
| **Number of Referrals Received** |  |
| **Number of Referrals Successfully Completed** |  |
| **Percentage Escalated back to Surgery** |  |
| **Number of Referrals Rejected by Pharmacy** |  |
| **Number and example of prescriptions received where patient could have been referred for a Pharmacy First Consultation** |  |

**Details of Escalations back to GP Practice**

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| --- | --- | --- | --- |
| **Date** | **Presenting condition** | **Consultation Outcome** | **Reason for Referral back to GP Practice** |
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| **Additional Notes** |
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**If you need any further information, please contact (name) at (email address/telephone number)**