YOURmeds Referral & Consent Form

# Section A: User’s details

\*Required Fields

|  |  |
| --- | --- |
| Liquid Logic Number\* |  |
| NHS Number: \* |  |
| Title \* |  |
| First Name(s) \* |  |
| Middle Name(s) |  |
| Last Name \* |  |
| Date of Birth \* (DD/MM/YYYY) |  |
| Phone Number \* |  |
| Address Line 1 \* |  |
| Address Line 2 |  |
| City \* |  |
| Post Code \* |  |
| Surgery Name \* |  |
| GP Name \* |  |
| Pharmacy Name \* |  |
| Pharmacy Address \* |  |
| User email address \* |  |
| Next Prescription Date \* |  |
| How many days of medication do you currently have \* |  |

# Section B: Pharmacy Choice and Consent

**How we will use your data to supply YOURmeds**

*We require your consent to enable the use of YOURmeds services. With your permission, we will use your NHS number to obtain details about your prescriptions and set up our services with your pharmacy*

*We obtain information on the medication type and the prescription renewal date. This enables a smooth transition to our services, so that the right medication arrives on time.*

*Please see our* [*privacy policy*](https://yourmeds.net/privacy-policy/) *for further details on how we use your data.*

*We will contact your pharmacy to set up your YOURmeds services. We will let you know once this is complete.*

*If your pharmacy decides not to work with us to provide the YOUR meds services or does not respond to us in a timely manner (we usually allow 2 days) you will need to choose a new pharmacy to dispense your prescriptions.*

*To avoid delays, you can decide now to choose an alternative pharmacy, if we are unable to provide YOURmeds services through your current pharmacy.*

**If we are unable to provide YOURmeds services through your current pharmacy, what would you like to do?**

 I will keep my current choice of pharmacy for now. I understand that, if YOURmeds is unable to provide services through my current pharmacy, I will be unable to access YOURmeds services at this time.

 I wish to automatically switch my choice of pharmacy to a new pharmacy to receive YOURmeds services. I understand that my prescriptions will be sent to and dispensed by the new pharmacy.

If We are unable to provide Yourmeds Services through your current pharmacy,with your permission we can automatically switch you to one of our pharmacy partners within your area.

# Section C: About Your Medication

We need to programme a schedule on when to take your medicines. To enable you to be as adherent as possible, please try and have large timeframes per medication round. Please note that changes to your medication schedule will be done via your pharmacy.

|  |  |  |  |
| --- | --- | --- | --- |
| Med Round | Start | End | Beeping |
| 1 |  |  | At Start of Round b) After 15 minutes |
| 2 |  |  | At Start of Round b) After 15 minutes |
| 3 |  |  | At Start of Round b) After 15 minutes |
| 4 |  |  | At Start of Round b) After 15 minutes |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | APP | Email | Text | Landline (Text to Speech) |
| How do you want your supporters to be informed |  |  |  |  |
| We will inform your Supporters 30 minutes after Round Starts. Are you happy with this? | | | Yes | No |

# Section D: Supporters - Nominated Family and Friends

Please nominate at least 1 friend or family member that will receive a notification when a medication has been forgotten, they will be responsible for contacting and reminding you. As a nominated responder the person/s below are agreeing to receive medication alerts via the YOURmeds smartphone app. They will require either an Android or Apple smart phone with data access to install the app and receive notifications. As a responder they are agreeing to make timely contact with the cared for person and carry out appropriate action as required \* Required Fields

|  |  |
| --- | --- |
| Responder 1 Name \* |  |
| Phone \* |  |
| Email Address \* |  |
| Relationship to Patient |  |
| Responder 2 Name \* |  | |
| Phone \* |  | |
| Email Address \* |  | |
| Relationship to Patient |  | |
| Responder 3 Name \* |  | |
| Phone \* |  | |
| Email Address \* |  | |
| Relationship to Patient |  | |
| Responder 4 Name \* |  | |
| Phone \* |  | |
| Email Address \* |  | |
| Relationship to Patient |  | |
| Responder 5 Name \* |  | |
| Phone \* |  | |
| Email Address \* |  | |
| Relationship to Patient |  | |

**Should you wish to change the order of response please contact YOURmeds on 02392 470001 and ask for Technical Support.**

# Section E: Sharing your data with the NHS and local authorities

*Through our services we aim to make medication simple, support people to stay independent, and reduce demand on NHS and social care services. With your permission, we would like to share data about your use of YOURmeds services with the NHS and local authorities to help evaluate the impact our services are having and to improve our services in future. We can only do so with your consent.*

*It is entirely up to you whether to give consent. Your choice will have no impact on access to our services and or the services you currently receive. You can withdraw consent at any time by contacting us.*

*Please see our* [*privacy policy*](https://yourmeds.net/privacy-policy/) *for further details on how we use your data.*

**Do you consent to us sharing data about your use of YOURmeds services with the NHS and local authorities to help evaluate the impact our services are having and to improve our services in future?**

 Yes

 No

Name of Person Completing this form:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Signature | Date |