POYC
Pharmacy of Your Choice

SERIAL NO: _____

For Official Use Only
COHORT NO:

CONSENT FORM
FOR A
CHANGE IN PHARMACY

Section [A] - To be filled in by the Patient

Name: …….. Surname:…… Identity Card No: ……

No. /Name of House: …….. Street: .....

Locality: …….. Post code: …….

Pharmacy of Choice ……. Locality: .....

Card – Yellow ☐ Pink ☐ Other ☐

Signature* _____ Date _____ Tel. No./ Mobile*_____

**Required field*

Section[B]* - To be filled in by the PATIENT'S appointed Person of Trust agreeing to this Change in the event that the patient will not be able to sign Section A of this Document.

I have been authorised by Mr /Mrs/Ms _____ to sign this **Consent Form** for the *Change in Pharmacy*.

Name	Surname	ID No	Signature*	Tel. No./ Mobile*	Date

Relation to Patient* _____

**Required field*

Section[C] - To be filled in by the Managing Pharmacist of the Pharmacy in the Scheme

I confirm that the patient above named may be registered with the pharmacy under my charge.

Name of Pharmacy:..... Pharmacy Licence No: .....

Locality: ..... When entitled to receive medicine: .....

Name of Managing Pharmacist: ..... No of Reg. Pharmacy Council: .....

Signature* _____ Date _____ Rubber Stamp* _____

* ***Required field***

DATA PROTECTION STATEMENT

THE MINISTRY FOR ENERGY AND HEALTH [HEALTH] shall be responsible for the information compiled in this Form. Every individual who fills in this Form reserves the right to request in writing, to see all the information compiled on him/her; s/he reserves also the right to request to remove any information which was compiled on him/her or to change any details which had changed. This information shall be used solely for the purpose of this Scheme and by the Pharmacists who are participating in the Scheme so as to facilitate service delivery of pharmaceutical *entitled* stock to the patients' homes.