Practice Feedback Form

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| Patient Name: |  |
| Patient Date of Birth: |  |
| NHS Number: |  |

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| --- | --- |
| Medication Name: |  |
| Dose/Strength: |  |
| Quantity Prescribed: |  |
| Prescribed Frequency: |  |

Reason for feedback:

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| --- | --- | --- |
| ☐ Patient no longer requires medication | ☐ Medication causing side effects | ☐ Patient prefers alternative treatment |
| ☐ Non-compliant with prescription | ☐ Advised to stop by another healthcare provider or clinician | ☐ Unable to take as prescribed |
| ☐ Taking medication differently than prescribed | ☐ Patient has concerns about medication | ☐ Receiving duplicate medication |
| ☐ Change in patient's condition | ☐ Medication out of stock or unavailable | ☐ Other (please specify): |

Details:*(why is this medicine is not being taken, or how is it being taken differently)*

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**How long has this been the case?** | ☐ <1 month | ☐ 1-3 months | ☐ 3-6 months | ☐ Over 6 months |  
  
Requested action/adjustments:

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Pharmacy Team Contact:

|  |  |
| --- | --- |
| Name: |  |
| Pharmacy: |  |
| Contact Number: |  |
| Email Address: |  |
| Date of Feedback: |  |