EDUCATION CAMPAIGN | MEDICINES AMNESTY

COMMUNITY PHARMACY CORNWALL

Practice Feedback Form

Patient Name:	
Patient Date of Birth:	
NHS Number:	

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

Reason for feedback:

☐ 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)

_____

_____

_____

How long has this been the case? | ☐ <1 month | ☐ 1-3 months | ☐ 3-6 months | ☐ Over 6 months |

Requested action/adjustments:

_____

_____

_____

Pharmacy Team Contact:

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