Gluten-Free Food Service
Patient Registration Form

NHS SCOTLAND

GPs please complete and sign this part of the form and allow patients to take it to the pharmacy of their choice.

Patient's full name					
Patient's CHI number					
Date of birth		**Male**		**Female**	
Address		**Postcode**			
Patient's GP/ Surgery					
Patient's contact telephone no. and /or e-mail address					
Condition	Coeliac Disease		Dermatitis Herpetiformis		
Carer Details (if appropriate)					

The above patient should receive the following GFFS units per month ____ (in figures) _____ (in words). Please see Coeliac UK recommended allocated units (www.coeliac.org.uk).

I have / have not (please delete) given prescriptions for one months supply of products.
I will no longer supply GFF for this patient from ____ / ____ / ____ (date).

GP's Signature		**Date**	
GP's Name		**GMC No**	

Pharmacists please complete and sign this part of the form.

Registration date				
Patient Care Record (PCR) completed	Yes		No	
Pharmacy Coeliac Annual Assessment required	Yes		No	
Name and address of Phamacy				

Pharmacist's declaration I declare that the information I have given on this form is correct and complete.

Pharmacist's signature		**Date**	
Contractor's Code		**Pharmacy Stamp**	

Patients please complete and sign this part of the form.
I agree to obtain my gluten-free foods from the above pharmacy as detailed.

Patient's signature		**Date**	