PAMAN Referral Form

Please supply the following information.
If you do not have access to all the information requested, please provide the information that you do have.

Referrer Name: .....

Address: .....

Telephone/ Mobile: .....

Date of Referral: .....

Service User Name: .....

Address .....

Postcode .....

Telephone/ Mobile .....

Date of Birth ..... NHS No. .....

Special considerations: Eg. Mobility, sensory impairments? .....

Would the patient benefit from PAMANs remotely operated secure medicine cabinet, REMLOK? .....

Reason for referral .....

Relative / carer
Alternative contact ..... Relationship .....

Address .....

Telephone/ Mobile .....

GP Practice: .....

Address .....

GP Name ..... Telephone .....

Pharmacy Name: .....

Address .....

Telephone ..... Email .....

Delivers free of charge Y / N Provides blister packs Y / N

Please send this completed form to: referrals@medicationsupport.co.uk

Any questions or clarifications please call at any time: 07914 739355 (Barry) or 07712 789118 (Norman)