

PHARMACY ADMISSION

Wintringham Program: _____ Date: ____ / ____ / ____

Mr / Mrs / Miss/ Ms: _____ D.O.B: ____ / ____ / ____

Address: _____

Phone Number: _____

Doctor: _____ Dr's Phone number: _____

Pharmaceutical Benefit Entitlement details: please tick

None

Safety Net

Pension

DVA

Concessional

Non-Concessional

Entitlement / Pension Number: _____ Exp Date: _____

Medicare Number: _____ Exp Date: _____

Allergies: _____

Generic Substitution OK? Yes No

Account/s forward to: _____

Name: _____

Address: _____

Suburb: _____ Postcode: _____

Provision of information for this document indicates acceptance of services from, and permission for Wintringham to provide confidential information to Pharmacy.

Client / Advocate signature: _____

Other: _____

Staff Name: _____ Signature: _____

