Wintringham

CSM Fm 4.1e

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: _____