**Request for authorisation to continue managed repeats**

Patient Name …………………………………………………………………………….

Patient Address ………………………………………………………………………….

………………………………………………………………………………………………

……………………………………………………………………………………………….

Patient DOB ……………………………………GP Practice………………………………..

I have assessed this patient and it is my opinion that they are currently unable to order their repeat medication directly from their GP practice by any of the following methods; Medicines Order Line (MOL), online, in person at the practice, in writing by post to the practice

The patient is unable to order repeat medication via the systems noted above because (please tick the box that applies):

has disability (e.g. impairment of memory, vision, hearing)

Other (please specify)….……………………………………………

……………………………………………………………………………….

I confirm that this patient will always be contacted and asked to confirm what items they require before each order is placed, and that I have the patient’s consent to order on their behalf via the MOL.

Name of assessor………………………………………………………….

Designation of assessor …………………………………………………..

Signature……………………………………………………………….. …..

Name of Pharmacy …………………………………………………..

Address ………………………………………………………………………

…………………………………………………………………………………

Phone number ……………………………………………………………….

Email ………………………………………………………………………….

Date…..……….……………………………………………………………….

Please submit the form to the GP practice via ……………………………..(surgery to complete)