Community Pharmacy Optometry Supply Service (CPOSS)

Cannock Chase CCG
North Staffordshire CCG
South East Staffordshire & Seisdon Peninsula CCG
Stafford and Surrounds CCG
Stoke-on-Trent CCG

Practice Name……

Practice Address **Practice Phone Number**

…… ……

……

……

To the Pharmacist.

Please supply to:

Patient Name …… **Patient Date of Birth** ……

Patient address

……

……

……

Preparation Required:

……

Optometrist Signature …… **Date** ……

Practioner GOC No ……

Written Oeder in accordance with Section 5 of Schedule 5, article 11(1)(a) of Statutory Insunstrument 1997 No 1830 as amended by Section 8 of Stautory Instrument 2005 No. 76

To be completed for patients who are exempt from NHS Prescription Charges

Patient Name …… **Date of Birth** ……

The Patient does not pay because:

A		**is 60 years of age or over or is under 16 years of age**
B		**is 16, 17 or 18 and in full-time education**
D		**has a valid maternity certificate**
E		**has a valid medical exemption certificate**
F		**has a valid prescription pre-payment certificate**
G		**has a prescription exemption certificate issued by Ministry of Defence**
L		**has an HC2 (full help) certificate**
H		**entitled to Income Support (IS) or Income-related Employment and Support Allowance (ESA)**
K		**entitled to Income-based Jobseeker's Allowance (JSA)**
M		**has a Tax Credit Exemption Certificate**
S		**has a Pension Credit Guarantee (including partners)**
U		**Entitled to Universal Credit and meets the criteria**

The information I have given is correct and complete and I confirm proper entitlement to exemption

I am the patient ☐ **I am the patient's representative** ☐

To be completed by the patient / patient's representative

I received ……. (insert number) medicine(s) from this pharmacy

Signed …… **Date** ……

Was evidence of exemption seen? **Yes?** ☐ **No?** ☐