NHS North Durham Clinical Commissioning Group

NHS Durham Dales, Easington and Sedgefield Clinical Commissioning Group

NHS Darlington Clinical Commissioning Group

FOOD/FLUID THICKENING VOUCHER

Patients should take this voucher to a Community Pharmacy in County Durham or Darlington for the voucher to be dispensed

Patient Name		GP	
Address		Address	
NHS number			
Date of birth	/ / /		

Please supply:-

1 x 175g Tin of Nutilis Clear By Nutricia

Instructions:

Voucher authorisation by:

Speech and Language Therapist Name	
Signature	
Qualification	
Date	
Contact Details	

Pharmacy Stamp

Pharmacist Signature _____

Pharmacist Name _____

PPA No: _____ **Date** / / /

****please ensure the patient completes the declaration on the reverse of this form****

Community Pharmacies should claim for products dispensed via food thickening voucher via a Community Pharmacy Food Thickening Claim Form (FT001) to NECS by the 5th of the month.

Food Thickening Vouchers should be retained in the community pharmacy.

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County Durham and Darlington NHS

TO THE PATIENT

Please complete this section:

☐ I have been supplied the medication as written on the front of this prescription form and paid £……. Prescription fee.

☐ I have been supplied, without charge, the medication as written on the front of this prescription form

A		Is under 16 years of age
B		Is 16, 17 or 18 **and** in full time education
C		Is 60 years of age or over
D		Has a current maternity exemption certificate
E		Has a medical exemption certificate
F		Has a current prescription pre-payment certificate
G		Has a War/MoD exemption certification number _____ please state
H		*Gets Income Support (give details of person receiving benefit)
M		*Is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate
S		*has a partner who receives Pension Credit guarantee credit
K		*Gets Income Based Jobseeker's Allowance
L		Is named on current HC2 charges certificate

Name (please print)	Date of birth

*print the name of the person (either you or your partner) who receive IS, JSA or Tax Credit

Patient's signature ……

Date……..

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