**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:-** ….. 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\*\***

**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 |

Date of birth

Name

(please print)

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

Patient’s signature ………………………………………………………………

Date………………………………………………………………………………..