

**COMMUNITY PHARMACY CHLAMYDIA SCREENING SERVICE – CLAIM FORM**

<b>Pharmacy Name/Address/Stamp:</b>	<b>Please return completed forms <u>BY 15<sup>TH</sup> OF MONTH</u> to:</b> Medicines Management Team Lockton House Clarendon Road Cambridge CB2 8FH      Fax: 01223 725401
<b>Month of claim:</b>	

**CHLAMYDIA SCREENING KITS:**

No	Date supplied	Sex	Age	Where heard about scheme?
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

No	Date supplied	Sex	Age	Where heard about scheme?
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				

**I confirm for this period that:**

- This service was provided by accredited pharmacy staff in accordance with the Chlamydia screening and treatment Local Enhanced Service

<b>Signature:</b>	<b>Name in block letters:</b>	<b>Date:</b>
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**FOR PCT USE ONLY:**

..... kits supplied @ £2.50 per kit	£.....	<b>TOTAL AMOUNT:</b>  £.....
<b>INFO FROM CSP:</b> ..... valid completed tests returned @ £5 per test	£.....	

<b>Authorised for PCT by:</b>	<b>Date:</b>
<b>Code: 2AB0001 8304</b>	