

COMMUNITY PHARMACY CHLAMYDIA TREATMENT – CLAIM FORM

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

CHLAMYDIA TREATMENT:

| No | Date supplied | Sex | Age | Outcome: A/E/D/* Referred | Caps/tabs/ oral suspension | Who referred to if excluded? | PCT USE ONLY |
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* A = Azithromycin caps/tabs 250mg x 4 or Azithromycin oral susp 200mg/5ml x 30ml
 D = Doxycycline caps/tabs 100mg x 14, E = Erythromycin caps/tabs 500mg x 28

I confirm for this period that:

- This service was provided by accredited pharmacy staff
- Supply and administration was in accordance with the NHS Cambridgeshire Patient Group Direction for administration and supply of Azithromycin, Doxycycline and Erythromycin for Chlamydia and the Chlamydia screening and treatment Local Enhanced Service

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|-------------------|-------------------------------|--------------|
| Signature: | Name in block letters: | Date: |
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FOR PCT USE ONLY:

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|--|----------------------|
| treatment consultations @ £7.50 per consultation £..... | TOTAL AMOUNT: |
| Total cost of treatment supplied £..... | £..... |
| Authorised for PCT by: | Date: |
| Code: 2AB0001 8304 | |