

|  |  |
| --- | --- |
|  | **Pharmacy Department**  United Lincolnshire Hospitals Trust  **www.ulh.nhs.uk** |

Dear Prescriber,

Please print and fill in the form below, make sure to complete both your signatures as requested, then submit to the Pharmacy Department at your relevant site as soon as possible.

**Please note electronic submissions cannot be accepted for governance reasons.**

If you are unable to print a copy, please go to your site Pharmacy Department where they can provide you with a printed version for you to complete whilst you are there.

If you have any concerns or queries, please contact Pharmacy team and ask for the site lead or a senior Pharmacy technician.

Yours sincerely

United Lincolnshire Hospitals Trust

Pharmacy Department



**PHARMACY SAMPLE SIGNATURE**

All Medical Staff must provide a sample signature if they will be prescribing anything through the pharmacy department. Failure to do this will result in delays for any prescriptions you prescribe.

Please complete the form in BLOCK CAPITALS:

SURNAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FORENAMES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

POSITION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SPECIALITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONTACT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BLEEP NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GMC NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONSULTANT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOSPITAL SITE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE COMMENCED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LEAVING DATE (if known):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When prescribing, please remember to sign and use your Trust issued personalised name stamp to authorise the administration and supply of the medication to the patient.

The personalised name stamps can be obtained from the Postgraduate Medical Education   
Department.

SAMPLE SIGNATURE: (please keep within box)

Full Signature Abbreviated signature for use on drug charts