Cornwall and Isles of Scilly NHS
Primary Care Support Agency

DIS 1

Sedgemoor Centre
Priory Road
St. Austell
Cornwall
PL25 5AS

Tel: 0845 170 8000
Fax: 01726 71777

SUPPLY OF MEDICINES AND APPLIANCES IN RURAL AREAS

(TO BE RETAINED BY THE PATIENT)

In rural areas patients may, in certain circumstances, have a choice between obtaining prescribed medicines and appliances from a pharmacy or from the doctor.

A patient may ask his doctor to supply him with medicines and appliances if he either:

(a) lives in an area which the PCT considers rural in character, at a distance of more than 1.6 kilometres (one mile) in a straight line from the nearest chemist (the 'one mile rule') and his doctor is entitled to dispense for him; or

(b) satisfies the PCT that he would have serious difficulty in obtaining any necessary medicines and appliances from a chemist because of distance or inadequate means of communication (the 'serious difficulty provision').

If you consider that the 'one mile rule' applies to you and you would like your doctor to dispense for you, please complete Part A & C of this form and ask your doctor to complete Part D which he will then forward to the PCT.

If, however, your doctor cannot dispense for you because you live within 1.6 kilometres (one mile) from a pharmacy but you consider you have serious difficulty in getting your medicines from the pharmacy, please include your reasons when completing Part B of the form.

Further information about the circumstances in which a doctor may dispense medicines and appliances for a patient can be obtained from:

Cornwall & Isles of Scilly PCSA
Sedgemoor Centre
Priory Road
ST AUSTELL
PL25 5AS

Tel: 0845 170 8000
Fax: 01726 71777

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"SERIOUS DIFFICULTY" APPLICATION FORM FOR DISPENSING BY DOCTORS

PART A (To be completed by the patient concerned)

FULL NAME……

ADDRESS……

……

HOME TELEPHONE NUMBER ……

DATE OF BIRTH…….. NHS NO (if known) ……..

I wish to obtain from my doctor medicines and appliances prescribed by him because (please tick appropriate box)

☐ I live in a rural area, at a distance of more than 1.6 kilometres (one mile) in a straight line from the nearest pharmacy, and my doctor is entitled to dispense to me. *(GO TO PART C OF THIS FORM)*

☐ I live within 1.6 kilometres (one mile) of the nearest pharmacy but have serious difficulty in getting medicines from there for the following reasons given overleaf. *(GO TO PART B OF THIS FORM)*

PART B

If you have not already done so, you should enquire of your local pharmacy whether they would be willing to collect and deliver your prescriptions. Please sate the name(s) of the pharmacies you approached and the response(s) received.

Name of Pharmacy	Collection & Delivery Service Available	
	Yes	**No**
……..	☐	☐
……..	☐	☐
……..	☐	☐

UNTIL THIS ACTION HAS BEEN TAKEN WE CANNOT PROCEED WITH YOU APPLICATION

Name & Address of GP Practice ……..

……

What is your reason for your Serious Difficulty in getting to the pharmacy?

……..

……..

	Yes	No
Are you able to leave your home without assistance?	☐	☐
Do you live alone?	☐	☐
If no, is the person you live with able to collect your prescriptions?	☐	☐

If no, please can you say why (e.g. housebound, disabled etc)……

……..……..

	Yes	No
Is there anyone else nearby who could collect your prescription for you?	☐	☐

	Yes	No
Is personal transport (car motor cycle etc) available to your household during normal shop opening times?	☐	☐
Is there a local bus service which gives you access to a pharmacy on a regular basis?	☐	☐

DO YOU RECEIVE ANY OF THE FOLLOWING SERVICES

	Yes	No		Yes	No		Yes	No
Home Help	☐	☐	District Nurse	☐	☐	Meals on Wheels	☐	☐

Any other, please specify……..

ARE YOU

	Yes	No		Yes	No		Yes	No
Home Help Disabled	☐	☐	in receipt of mobility allowance	☐	☐	in receipt of disability living allowance	☐	☐

Any other, please specify……..

DO YOU HAVE

	Yes	No		Yes	No
A home telephone	☐	☐	Blue Badge (Disabled Driving Scheme)	☐	☐

DO YOU NORMALLY

	Yes	No		Yes	No
Visit your doctor	☐	☐	Receive a home visit from your doctor	☐	☐

Where is your nearest pharmacy? ……..

Do you use this pharmacy regularly, if no which pharmacy do you use? ……..

How do you obtain your medicines at present? ……..

In what way would the approval of this application benefit you? ……..

……

……

PART C

I hereby certify that the above information is correct and I request the Primary Care Trust to consider my application under the 'Serious Difficulty' clause of the Pharmaceutical Regulations. I wish to make application to the Primary Care Trust for my doctor to supply me with drugs and appliances in accordance with the appropriate Regulations.

Signed…….. Date……..

PART D (TO BE COMPLETED BY YOUR DOCTOR AND SENT TO THE PCSA)

I received this request on …….. and support the application. The practice is willing to supply any necessary drugs and appliances to this patient who is on the list of persons for whom I provide general medical services.

Doctor's signature …….. Date ……..