

**Application for Prepayment Prescriptions for Care Leavers**

|  |  |  |
| --- | --- | --- |
| First Name: |  | |
|  | | |
| Last Name: |  | |
|  | | |
| DOB: |  | |
|  | | |
| Address (*current*): |  | Post Code: |
|  | | |
| Email Address:  **\*** Needed as prepayment certificate will be emailed to you **\*** |  | |
|  | | |
| Telephone Number: |  | |
|  | | |
| NHS Number (if known): |  | |
|  | | |
| General Practitioner (*GP)* |  | |
|  | | |
| General Practitioner (GP) Address |  | Post Code: |
|  | | |
| Leaving Care Worker Contact Details:  *(Telephone Number)*: |  | |
|  | | |
| Which Local Authority looked after you: |  | |

I consent to Lincolnshire ICB using my personal details to purchase a prepayment certificate for prescriptions and monitoring purposes. (Once the certificate has been purchased your data will not be kept by the ICB, it will be deleted).

I consent to Lincolnshire ICB contacting Barnardo’s if confirmation is required that I am a Care Leaver.

|  |  |  |
| --- | --- | --- |
| Name: | Signature: | Date: |

# 

# Please email the completed form to**: licb.careleavers@nhs.net**

# For Office use only:

Prescription approved for: - 3 months/12 months, Signed ……………………………………………………

Name ………………………………………………………………. Date on behalf of Lincolnshire Integrated Care Board.