



HIGH TECH DRUGS ARRANGEMENTS

CHANGE OF NOMINATED PHARMACY FOR EXISTING HIGH TECH CLIENTS

Part 1.

High Tech Patient Details:

Patient Name: _____

Patient Address: _____

Patient Telephone Number:
(Please include pre-fix)

Card Number:
(Please include correct patient code letter)

Patient's PPSN:

Please tick Scheme under which the patient is authorised to receive High Tech Medicines:

GMS: DPS: LTI: HAA: OTHER:

Patient Signature: _____ Date: _____

Part 2.

Name of **Current Nominated** Pharmacy: _____

Address of **Current Nominated** Pharmacy: _____

Pharmacy GMS Contract Number (If available):

Part 3.

Name of **New Nominated** Pharmacy: _____

Address of **New Nominated** Pharmacy: _____

Pharmacy GMS Contract Number:

Month of change from old Pharmacy to New Pharmacy:

Your new Nominated Pharmacy should forward this form along with a copy of your High Tech Prescription to the High Tech Coordination Unit – email: pcrs.hitech@hse.ie