Leybourne Pharmacy

Blood Pressure Monitoring
Patient Consent Form

Section 1 to be completed by the Pharmacist

Leybourne Pharmacy

9 Leybourne Parade

Brighton

BN2 4LW

Pharmacy Stamp

I (the pharmacist) confirm I have explained to the patient how the Blood Pressure monitoring service works and have assessed the patient's risk factors.

Name of Pharmacist _____

Signature _____

Section 2 to be completed by the Patient undertaking the service

- The information provided is true to the best of my knowledge
- To my knowledge there is no reason why I cannot participate in this service
- I understand and agree to the disclosure of my information being passed to my GP where appropriate
- I consent to my personal date, results and blood pressure measurements being stored by the pharmacy
- I consent to the use of anonymised data for statistical purposes
- I understand that I must inform the pharmacist of any change in my medical circumstances
- I understand and have been advised that I may require a further appointment with the pharmacist. In some cases this may involve further tests requested by my GP/Practice nurse

Name of patient _____

Date of birth _____

Signature _____

Date _____