GRASSENDALE

Medical Practice

Application for Exemption to Order Repeat Prescriptions by Email

Purpose of this form: This form is only for the carers, parents, or guardians of patients who cannot use the standard ordering methods (NHS App, or paper slip) due to specific circumstances outlined in our Repeat Prescription Ordering Policy.

Please complete all sections and return the form to the Practice Manager via reception or our practice email address. A decision will be communicated to you within 10 working days.

Section 1: Patient's Details

Full Name of Patient:

Patient's Date of Birth:

Patient's NHS Number:

Patient's Address:

Section 2: Applicant's Details (Parent / Guardian / Carer)

Your Full Name:

Your Relationship to the Patient:

Your Contact Telephone Number:

Your Email Address for Prescription Requests:

(Important: If approved, we will only accept requests from this specific email address)

Section 3: Reason for Exemption Request

Please put an X in the **one** box that applies to the patient for whom you are requesting this exemption.

[ ] **Cohort A: Patient is a child aged 11-15.** *I understand this is a temporary arrangement to ensure continuity of care while the practice arranges an appointment to assess the child's consent for me to have formal proxy access via the NHS App.*

OR

[ ] **Cohort B: Patient is a vulnerable adult.** *I confirm that the patient is unable to use the NHS App or other digital services (e.g., due to cognitive impairment, severe disability, or lack of any digital access)* ***AND*** *I, the applicant, am not registered as a patient at this practice myself.*

Please provide a brief, non-clinical explanation if you feel it is necessary:

_____

_____

Section 4: Declaration and Consent

By signing this form, I declare that:

- I understand that ordering prescriptions by email is an exception to the practice policy and is only granted in specific circumstances.
- I acknowledge and accept the risks of using a non-secure email system to transmit patient information, as outlined in the practice policy.
- I consent to the practice storing this form and using my details to process this exemption request, in line with UK GDPR.
- I agree to inform the practice immediately if the patient's circumstances change (e.g., proxy access is granted, the patient becomes able to use the NHS App).
- If applying for a child (Cohort A), I agree to work with the practice to arrange and attend the necessary appointment(s) to establish formal proxy access.

Signature of Applicant: _____

Date: _____

FOR PRACTICE USE ONLY

Date Received:	
Reviewed By (Name & Role):	
Decision:	☐ **Approved** ☐ **Declined**
If Declined, Reason Given:	
Date Applicant Notified:	
Action Taken:	☐ Patient record flagged with details of exemption and approved email address. ☐ Applicant added to Exemption Register.
Exemption Review Date:	