CARE 24/7
HEALTHCARE

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MM11

Covert Medication - Administration Guidance from Community Pharmacist

A: SERVICE USER DETAILS		
Surname:	**First Name(s)**	**Date of Birth:**
Pharmacist:	**GP:**	**Advocate:**

B: PHARMACEUTICAL GUIDANCE FOR COVERT MEDICATION

MEDICINE	Format (e.g. tablet, capsule, syrup)	Advice from Pharmacist regarding the covert administration of this medicine	Signature (Pharmacist)	Date