## Appendix One

**Transportation of Drugs**

**Early Supported Discharge Team**

**Patient Name:**

**Address:**

**NHS no:**

**DOB:**

I give consent for an ESD staff member to collect my medications from the pharmacy and deliver them to me at home, and/or to return my medications of which I no longer use to the dispensing pharmacy for disposal (please delete as appropriate).

**Medications collected and delivered:**

Loose medications/boxed medications/blister pack medication/pill pouch medication

(Please circle above)

**Included medications:**

Patient Signature & Date:……………………………………………………

Pharmacist Signature & Date:………………………………………………

Therapist Signature & Date: ………………………………………………..

Date and Time of completion: ………………………………………………