DIABETES AFRICA

In partnership with: DIABETES SOUTH AFRICA

Form to enable a representative to collect medicines on behalf of a patient in isolation or shielding due to COVID-19.

Patient Name	
Patient Address	
Patient Date of Birth	
Patient I.D number	
Patient phone no.	

Dear Pharmacist,

This letter is to show that I am currently unable to collect my medication because I am shielding or am in self-isolation due to the COVID-19 pandemic.

I give my express permission for the representative named below to collect my medication on my behalf, and I have informed them that they will need to provide identification before they can collect the prescription.

Patient Representative Name	
Patient Representative Address	
Patient Representative Date of Birth	
Representative Relationship to Patient	

Patient Signature		Date	/ /
Patient Representative Signature		Date	/ /

For Pharmacy Use

Letter received by			
Date letter received			
Date of meds collection	/ /	Representative I.D checked?	Yes / No