**East Kent Joint Formulary – Dressing Inclusion Request**

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| Before completing this form, please email ACCG.eastkentprescribing@nhs.net for the application reference number. Please include your contact details and the name of the medicine. |
| Application reference number: | XXXXXXX |

This form must be used to document all requests for new dressings to be included in the East Kent First Choice Dressings List. Requests will be reviewed at the East Kent Joint Formulary Management Group. A confirmation email (containing a copy of the request details) will be sent within two working days of submission. Information on the group decision will be sent to the lead HCP within 2 weeks of the joint formulary meeting.

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| **1a** | **Details of requesting Healthcare Professional (HCP)***(if multiple HCPs involved, copy & complete this section for each HCP)* |
| Name |  |
| Professional group *(e.g. Doctor/Nurse/ Pharmacist/etc.)* |  |
| Organisation |  |
| Department/team  *(if applicable)* |  |
| Contact number |  |
| Email address |  |
| **1b** | **Declaration of interests for requesting HCP** |
| In line with governance policies (with which the applicant is expected to be familiar) any interest the applicant or their service have in the manufacturer of the requested medicine must be declared – this includes sponsorship for study leave or lectures. Applications with major undeclared conflicts of interest will be rejected (including inappropriate lobbying by industry). |
| Have you or your department/team/Trust received any sponsorship from the manufacturers? | [ ]  Yes | [ ]  No |
| Do you have any financial interest in the manufacturing company? | [ ]  Yes | [ ]  No |
| Were you involved in any sponsored clinical trials of the drug? | [ ]  Yes | [ ]  No |
| If yes to any of the above sections, please provide details:  |
| **2a** | **Details of the organisation’s supporting pharmacist** |
| Name |  |
| Organisation |  |
| Department/team  *(if applicable)* |  |
| Contact number |  |
| Email address |  |
| **2b** | **Declaration of interests for the organisation’s senior pharmacist** |
| In line with governance policies (with which the applicant is expected to be familiar) any interest the applicant or their service have in the manufacturer of the requested medicine must be declared – this includes sponsorship for study leave or lectures. Applications with major undeclared conflicts of interest will be rejected (including inappropriate lobbying by industry). |
| Have you or your department/team/Trust received any sponsorship from the manufacturers? | [ ]  Yes | [ ]  No |
| Do you have any financial interest in the manufacturing company? | [ ]  Yes | [ ]  No |
| Were you involved in any sponsored clinical trials of the drug? | [ ]  Yes | [ ]  No |
| If yes to any of the above sections, please provide details:  |

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| **3** | **Details of East Kent CCG Prescribing Advisor** |
| Name |  |
| Organisation |  |
| Contact number |  |
| Email address |  |
| Does the CCG receive any sponsorship from this manufacturer? | [ ]  Yes | [ ]  No |
| Is there a conflict of interest for the prescribing advisor with this application? | [ ]  Yes | [ ]  No |
| If yes to either of the above sections, please provide details: |

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| **4** | **Details of current and proposed dressings are provided in Appendix 1** |

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| **5** | **Decision** |
| This medicine is approved for inclusion onto the East Kent Joint Formulary | [ ]  Yes | [ ]  Yes, with modifications identified below  | [ ]  No |
| Modifications to submission (if required) |  |
| Reason for decision |  |
| Chair of East Kent Joint Formulary Management Group signature |  |
| Date |  |

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| **6** | **KCHFT Decision** |
| This medicine is approved for use within KCHFT | [ ]  Yes | [ ]  Yes, with modifications identified below  | [ ]  No |
| Modifications to submission (if required) |  |
| Reason for decision |  |
| Chair of committee signature |  |
| Date |  |
| Division/Speciality Lead signature |  |
| Date |  |