APPENDIX 2 **H PYLORI**

MONTHLY ACTIVITY CLAIM FORM

MONTH: ……. **YEAR: ……..……..**

Pharmacy Name and Address: ……..

……..

Signed Lead Pharmacist: …… Date: ……..

Name of Lead Pharmacist: …….. CAMRx A/c No: ……..

Please complete clearly

Date of Test	Referring GP	Practice Address	CCG	GP Practice Code	Filed or Referred
TOTAL No. of Tests					

Please return completed form to:

CAMRx Ltd, 54-66 Silver Street, Whitwick, Leicestershire, LE67 5ET

pa@camrx.co.uk Fax: 01530814914