Ashwood Medical Centre

Repeat Prescription Request Form

Patient Name: _____ Date of Birth: __ /__ /__

Address:

_____

_____

	Name of Tablet/liquid	Dosage	How often	Tick this box if you need this medication
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

If you require further medications please continue your list on another request form.
If you have any difficulty completing this form, ask your pharmacist for assistance.
Please post or leave completed forms at reception.
Prescriptions will be available within 2 working days of receipt of request.

Have you attended the clinic for a medication review in the past 6 months? Yes / No I confirm that I request all of the above medications be re-prescribed for my personal use.

Patient Signature: _____ Date: __/__/___

Patient's telephone number

If you are unable to collect the script yourself please arrange for the nominated person to sign here so the surgery are aware _____

Date: __/__/___