Repeat Prescription Request Form

Please allow 2 Working days before collection, excluding weekends and bank holidays.

Date……..

Patient name……..……

Address……..……..……

Date of birth…….. Contact number……

Pharmacy that you would like to collect your medication from……..
(Please note that you may need to allow extra time for your prescription to be processed at the pharmacy)

	Name of drug required	Strength	Form	Dosage	Quantity
1					
2					
3					
4					
5					
6					
7					
8					
9					

If your prescription is to be collected by a pharmacy, please state name of

pharmacy……..

If you would like your prescription to be sent electronically to a pharmacy, please state the

pharmacy…….

Date…….

For office use only:	
Items Issued	□
Compliance Problem	□
Review Date Exceeded	□
Drug Not Authorised on Repeat	□
Drug Not on Past History	□
Other	□

GP/Pharmacist Comments

PHARMACY TO REQUEST FUTURE ORDERS DUE TO EXCLUSIONS	
PATIENT OVER 75	□
PATIENT TAKING 8+ MEDICATIONS	□
OTHER please state	

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