REPEAT SLIP

Date of Birth……

Full Name……..

Address……..

……

PLEASE PRINT

DRUG NAME AND STRENGTH

1)……

2)……

3)……

4)……

5)……

TO BE COLLECTED FROM: (PLEASE TICK)

RECEPTION DESK ( )
BOOTS PHARMACY ( )
BOOTS HIGH STREET ( )
TESCO ( )

PLEASE ALLOW 5 WORKING DAYS BEFORE COLLECTION

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