OLD SCHOOL SURGERY – REPEAT PRESCRIPTION REQUEST

PATIENT NAME:
ADDRESS:
TEL NO:

DOB:
DATE TODAY:

MEDICATION / ITEM	DOSE	QUANTITY	REASON

PLEASE ALLOW AT LEAST 3 WORKING DAYS TO PROCESS YOUR REQUEST

Your prescription may take longer than this if you request an item which is not on 'repeat' prescribing

PLEASE CONFIRM WHERE YOU WOULD LIKE TO COLLECT FROM: (please tick)

☐ Collect from usual pharmacy – please specify where .....

☐ Collect from Reception