REQUEST FOR PRESCRIPTION

It is very important that we are given the name, strength and dosage of each item requested

We require 48 hours to process a repeat prescription.

Medication that is not on repeat will take a little longer

If you require a new medication, it would be helpful to know why you need it and whether you have used it in the past

DATE:

NAME:

DOB:

ADDRESS:

TEL NO:

IT IS IMPORTANT THAT YOU COMPLETE THIS REQUEST FORM CLEARLY IF YOU DO NOT - IT COULD RESULT IN A DELAY IN PROCESSING YOUR REQUEST

PLEASE TURN OVER TO COMPLETE THE FORM TO REQUEST YOUR MEDICATION

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PRESCRIPTION REQUESTED:

NAME OF DRUG	STRENGTH	DOSAGE
ALLERGIES		

Please use the space below if you would like to add anything

Smoking Questionnaire ***Please help us to update our records by completing this questionnaire***			
What is your smoking status *Please tick the appropriate box* ✓			How many
A	Never smoked tobacco		
B	Ex-smoker		
C	Current smoker		
Would you like some advice on stopping smoking? Yes ☐ No ☐			

ETHNICITY – please state
What is your first language?

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