Repeat Prescription Request Form

Please allow 48 hours before collection, excluding weekends and bank holidays.

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	Quantity

Please state why you are requesting the drug, if it is not one of your usual repeat medications.

Date….……………….