REPEAT PRESCRIPTION REQUEST

NAME :_____ DATE:_____

ADDRESS _____

D.O.B. _____ TELEPHONE NO_____

1. _____ 5._____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

These forms can be hand delivered, posted or faxed to the surgery. (Fax number 053 94 20505)

PLEASE GIVE 48 HOURS NOTICE

Due to new data protection legislation you must collect your own prescription. If you are unable to collect your script, you can request that your Pharmacy collects it for you.

You can give written consent for another person to collect your script. The person you nominate to collect your script will need to provide their photo identification each time they come to collect your script

Consent for collection of prescription

Date: _____

I _____ (Print name) D.O.B.: _____/ _____/ _____

Give consent to:

_____ (Print nominated person's name)

To collect my prescription from Gorey Family Practice for me.

The nominated person named above is aware that they must show their ID to staff in Gorey Family Practice each time they wish to collect my prescription.

Signed : _____