# REPEAT PRESCRIPTION REQUEST FORM

**NAME: ………………………………………………………………………………. DOB: ……………………………………………**

**ADDRESS: ………………………………………………………………………………………………………………………………….**

**DATE: ………………………………… *NOMINATE A PHARMACY: ……………………………………………………..……**

**COMMENTS…………………………………………………………………………………………………………………………….**

**PLEASE ALLOW 3 WORKING DAYS FOR COLLECTION. PLEASE DO NOT ORDER MORE THAN 10 DAYS PRIOR TO THE DUE DATE.**
**TO ENSURE SAFE PRESCRIBING "URGENT" REQUESTS WILL ONLY BE CONSIDERED IF CLINICALLY APPROPRIATE.**

| **DRUG** (Brand name/generic) | **DOSE** (e.g.5mg) | **DIRECTIONS** (e.g. Once Daily) | **QTY** |
|---|---|---|---|
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*** PRESCRIPTIONS WILL BE SENT DIRECTLY TO THE NOMINATED PHARMACY.**


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