**Garden City Surgery**

**Repeat Prescription Request Form**

**Please allow 3 Working days before collection, excluding weekends and bank holidays.**

**Date of request:**

**Patient Full name:**

**Address:**

**Date of birth: Contact number**

**(Please note that you may need to allow extra time for your prescription to be processed at the pharmacy)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|   | **Name of drug required** | **Strength** | **Form** | **Dosage** | **Quantity** |
| **1** |   |   |   |   |  |
| **2** |   |   |   |   |   |
| **3** |   |   |   |   |   |
| **4** |   |   |   |   |   |
| **5** |   |   |   |   |   |
| **6** |   |   |   |   |   |
| **7** |  |   |   |   |   |
| **8** |  |   |   |   |   |
| **9** |   |   |   |   |   |

**Your prescription will be sent electronically to your preferred pharmacy *(exceptions will apply to some items),* Please state the,**

**Pharmacy Name:………………………………………………Pharmacy Postcode:………………………………..**

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| **FOR OFFICE USE ONLY** |
| **Item issued :**  |
| **Item refused: Reason:** **Not Due yet: Need Re-authorisation Other**  |
| **Staff Initials :** |