LISSON GROVE AND WOOLWELL MEDICAL CENTRE

REPEAT PRESCRIPTION REQUEST FORM

WORKING WITH YOU TO IMPROVE YOUR CARE

Details of Person requesting medication		**Details of patient**	
Name of requestor		Name of Patient	
Signature of requestor		Date of Birth	
Date of request			
Contact phone number		Contact phone number	

Please delete as necessary	**I am the patient OR I represent the patient**
Relationship to patient (Pharmacist- please add business stamp here)	

PLEASE ALLOW 2 COMPLETE WORKING DAYS FOR REPEAT PESCRIPTIONS.

Prescriptions will be ready for collection at the end of the relevant clinic ie after 12 noon or after 5pm

Details of medication requested

Name of medication required	Amount required (eg 1 month/ 30 tablets etc)	Reason for request (eg use infrequently so not on my regular repeat form)

Have you registered to manage your repeat prescriptions on line? Please ask at reception.

If you have any further comments, please add them below.