**Acute Medication Request – Sandy Lane Surgery**

The doctors need all the following information to be able to process your req. accurately.

If the form is not fully completed your request will be denied.

|  |
| --- |
| Full Name Date of Birth Add: Home Tel: Mobile Tel: Email:  |
| Name of medication being requested  |   |
| Strength and Dose  |   |
| Reason for request i.e. symptoms – please  |   |
| use the space below if necessary  |   |
| Date you last had this medication?  |   |
| Who previously issued this medication? i.e.  |   |
| GP or hospital consultant or specialist?  |   |
| Do you suffer from any allergies if so what?  |    |
| Is it possible you could be pregnant?  |    |
| Would you like this medication to go on your  |   |
| repeat list?  |   |

ANY MORE INFORMATION