KILLYNETHER PRACTICE
REQUEST FOR ALTERNATIVE MEDICATION DUE TO SUPPLY ISSUES

NAME OF PATIENT: DOB:	ADDRESS:
HOME TELEPHONE:	MOBILE TELEPHONE:

Patient: please ensure you have tried at least two to three different Community Pharmacies before requesting an alternative.
If you need a prescription issued for the specific item, please request this and a separate prescription can be issued.

Community Pharmacy: please provide **a <u>list of alternatives that are available</u>** and in stock before completing this form. This is to ensure an alternative is supplied that is available otherwise it will cause unnecessary delay.

Medication name	
Strength (e.g. 5mg)	
Reason for taking medication if known (e.g. diabetes, high blood pressure)	
Available alternatives **(advice from Community Pharmacy)**	
Community Pharmacy	
Contact details	