REPEAT PRESCRIPTION FORM

PATIENT DETAILS

NAME: _____

ADDRESS _____

Date of Birth _____

Designated Pharmacy: _____

NB/ Contact Telephone No. _____

All requests for repeat prescriptions must be submitted in writing 72 hours in advance. You may wish to use this order form to write your medication OR to attach the pharmacy labels to this order form OR alternatively you can order your repeat prescription by emailing list to rathdrummedical2020@gmail.com

Your prescription will be sent directly to your nominated pharmacy. Please note Private Prescriptions incur a fee of €20 payable in advance.

No.	Name of medication	Dosage(mg/mls)	Number taken	How many times per day
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				

☐ **I confirm that I am ordering the above medication for my own use ONLY.**

☐ **I acknowledge that I have agreed to participate in the eScript program and consent to the sharing of my personal data including my mobile phone number with my selected pharmacist.**

PATIENT SIGNATURE _____ **Dated** _____