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The Milligan Family Practice

REPEAT PRESCRIPTION REQUEST FORM

Patient Name: _____ Date of Birth: _____

Address: _____

GMS No. _____ Phone No. _____

	MEDICATION	STRENGTH	DOSAGE	TYPE	DURATION
1.	EG. ASPRIN	75mg	1 Daily	Tablet	1 Month
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

PLEASE NOTE THAT ALL PRESCRIPTION REQUESTS TAKE 2 WORKING DAYS TO PROCESS

If you require further medication please request a 2nd form.
If you are having difficulty completing this form please ask your pharmacy for assistance.
Please leave into reception or email to prescriptions@milligan.ie.
Have you attended for a medication review in the last 12 months? **YES/NO**
I confirm that I request that all the above medications are for my personal use.

Signed: _____

OFFICE USE ONLY:

Date Received:_____ Date Due:_____ Date Issued: _____