**REPEAT PRESCRIPTION REQUEST FORM**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**GMS No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NEW PHARMACY USED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NB: Must be Completed**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **MEDICATION** | **STRENGTH** | **DOSAGE** | **TYPE** | **DURATION** |
|  | **EXAMPLE: ASPRIN** | **75mg** | **1 Daily** | **Tablet** | **1 Month** |
| **1.** |  |  |  |  |  |
| **2.** |  |  |  |  |  |
| **3.** |  |  |  |  |  |
| **4.** |  |  |  |  |  |
| **5.** |  |  |  |  |  |
| **6.** |  |  |  |  |  |
| **7.** |  |  |  |  |  |
| **8.** |  |  |  |  |  |

**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: \_\_\_\_\_\_\_\_\_\_\_\_**