# Castlebar Family Practice

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## Repeat Prescription Request Form

Patient Name: _________________________________ Date of Birth: __ /__ /__

Address: ___________________________________________________________ Tele: _________________

| | MEDICATION | STRENGTH | FORM | DOSAGE |
|---|---|---|---|---|
| Eg | Asprin | 75mg | Tablets | One Daily |
| 1 | | | | |
| 2 | | | | |
| 3 | | | | |
| 4 | | | | |
| 5 | | | | |
| 6 | | | | |
| 7 | | | | |
| 8 | | | | |
| 9 | | | | |
| 10 | | | | |

- If you require further medications please continue your list on another request form.
- If you have any difficulty in completing this form, ask your pharmacist for assistance.
- Please post or leave completed forms in the post box inside the front door.
- Prescriptions will be available within 3 working days of receipt of this request.
- Have you attended the clinic for a medication review in the last 6 months? **Yes/No**

- I confirm that I request all of the above medications be re-prescribed for my personal use.

**Patient Signature: _________________________** **Date __ /__ /__**