

# Glengarriff Medical Centre

## Glengarriff, Co Cork P75 FK61

### REPEAT PRESCRIPTION REQUEST FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

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


Tel no.: \_\_\_\_\_ Medical Card No.: \_\_\_\_\_

- We require 48 hours notice from receipt to process repeat prescriptions. Please take into account weekends and bank holidays.
- Written requests can be posted, dropped into the designated box at reception or completed through our website – Glengarriff Medical Centre
- Please complete your list of medications below
- Please note prescriptions can be requested for up to 6 months but your doctor may not issue your requested duration if a review appointment is required in this period.
- Please fill the form as per the example given

No.	Medication	strength	Dose	Months Required 1 - 6
<i>Example</i>	<i>Aspirin</i>	<i>75mg</i>	<i>One daily</i>	<i>1 month</i>
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				

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

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Designated Pharmacy \_\_\_\_\_ 

We will email the prescription directly to the pharmacy of your choice