PRESCRIPTION REQUEST FORM

PLEASE FILL YOUR PRESCRIPTION FORM

(We aim to have all prescription requests ready within 4 working days.)

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NAME: _____ **PHONE No: _____**

ADDRESS: _____ **USUAL CHEMIST: _____**

DURATION (months): _____

Item	Medication Name	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
	NEW CHANGES/REQUESTS (e.g. from hospital visit)		
1			
2			
3			
4			
5			

REASON PRESCRIPTION MAY NOT BE DONE BY DOCTOR:

_____

You can:

Prescription Request Forms can be delivered to the Surgery by the following means:

1. Deliver this from to the surgery during opening hours 8-1/2-5 MON-FRI
2. Post – please post to Prescriptions The Cremore Clinic 66 Ballygall Road East Dublin 11
3. Fax – please fax to 01-8640255