

Annagh Medical Centre Repeat Prescription Form

Annagh Medical Centre, Doctor’s Road, Ballyhaunis, Co. Mayo. F35 X932. Tel: 094 9632232 Fax: 094 9632355 **www.annaghmedicalcentre.com**

PLEASE POST OR HAND INTO SURGERY PRESCRIPTION BOX OR RECEPTION

WE NO LONGER ACCEPT PHONECALL REQUESTS.

We only accept requests using this form or online via our website [**www.annaghmedicalcentre.com**](http://www.annaghmedicalcentre.com)

**For your safety and correct prescribing :**

All medications should be requested at the same time.

We aim to complete request within 48 hours, but would appreciate 5 working days notice

If you have any difficulty completing this form please ask your pharmacist or family member for assistance

All prescriptions will be for three to six months at a time unless restrictions or safety issues apply.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE | SURNAME | FIRST NAME | Date Of Birth | CHEMIST |
|  |  |  | / / |  |

|  |  |
| --- | --- |
| No | Medication– Please write name of medication you require below |
| 1 |  |
| 2 |  |
| 3 |  |
| 4 |  |
| 5 |  |
| 6 |  |
| 7 |  |
| 8 |  |
| 9 |  |
| 10 |  |
| 11 |  |
| 12 |  |
| 13 |  |
| 14 |  |
| 15 |  |

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

**Patient’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_**