

DUNBLANE MEDICAL PRACTICE

PRESCRIPTION SPECIAL REQUEST FORM

Personal Details

Today's Date	
Name	
Date of Birth	
Tel/Contact Number	
Usual GP	

What Medication do you require?

Name of Medication	
Dose, eg 5 mg tabs	
Quantity	
Is this on your repeat?	
If not, why do you take this?	
When did you last have this?	
Collect from: <input type="checkbox"/> Well Place Pharmacy <input type="checkbox"/> High St Pharmacy <input type="checkbox"/> Deliver (Housebound Only) <input type="checkbox"/> Surgery	

PLEASE ALLOW 48 HOURS FOR YOUR REQUEST TO BE PROCESSED

For GP Use Only:

Prescription appropriate and added to repeat	GP to Tick
Prescription appropriate on this occasion but must discuss with GP before further prescription issued	
Prescription not appropriate and not issued – Discuss with GP	
Comments:	

Office Use:

	Please Tick & Any Comments
Actioned by Receptionist	
No Action Required	
Patient Informed	

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