**PRESCRIPTION RENEWAL FORM**

**We kindly ask that all prescription renewal requests be made using this form.**

**We require a minimum of 48 Hrs to process repeat prescriptions.**

**Your prescription will be sent electronically to your nominated pharmacy.**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number\*:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(essential)**

**Medical Card Patient: Private Patient: (We will contact you for payment.)**

**Medical Card Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I consent to Edenderry Clinic accessing my medical files**

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BLOCK CAPITALS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **I consent to receiving SMS text messages Please tick the box**
* **Which pharmacy would you like your prescription sent to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name of pharmacy)**
* **Is this request for regular medication or for medication prescribed occasionally?**
* **Regular item 66 Prescribed occasionally**
* **IF ITEMS ARE ONLY PRESCRIBED OCCASIONALLY WE MAY NEED TO CONTACT YOU TO DISCUSS IN MORE DETAIL.**

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| **Medications** |
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**ANOTHER PAGE CAN BE ADDED IF NECESSARY. DID YOU COMPLETE ALL THE SECTIONS ABOVE?**