Prescription Request Form

Name: _____(first) _____(surname)

Date of birth: _____

PPS Number: _____

Contact Number_____

Medical Card Number / GP Visit Card Number (if applicable) _____

Address: _____

_____

Nominated pharmacy name and address: _____

_____

Items required

*Repeat of all long term routine medication ( ) ✓

Medication	Dose	Quantity
(eg) Paracetamol	500mg	56
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Two working days notice must be given for prescriptions. Your prescription will be delivered electronically to your nominated pharmacy