Oakwood
Medical Clinic

Repeat Prescription Request Form

Patient Name: _____ Date of Birth: __ / __ / __

Address: _____

	MEDICATION	STRENGTH	FORM	DOSAGE
Eg	Aspirin	75mg	Tablets	One daily
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

- If you require further medications please continue your list on another request form.
- If you have any difficulty completing this form, ask your pharmacist for assistance.
- Please post or leave completed forms at reception.
- Prescriptions will be available within **2 working days** of receipt of request.

- Have you attended the clinic for a medication review in the past 6 months? **Yes / No**

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

Patient Signature: _____ **Date:** __ / __ / __