PRESCRIPTION REORDER FORM

Oakwood Medical Clinic

Name: _____ **DOB:** __ /__ /__

Address: _____

PREFERRED CHEMIST: _____

MEDICATION	DOSE & FREQUENCY	Once off	6 MTH

Have you attended for a medication review in the last 6 months? **Y** ☐ **N** ☐

This form may be e-mailed to **info@oakwoodmedical.ie**

All regular medications should be requested, if possible, at the same time. Do not order medication unless needed. Please allow **48 hours** for processing.

Our policy now is to email your prescription securely to your chemist of choice. Please ensure that you have detailed your preferred chemist above.

I confirm that I request all of the above medications for my personal use.

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

Mobile (in case we need to contact you to discuss your request): _____