

Prescription Request Form

NAME:

DOB:

ADDRESS:

TELEPHONE:

We would be grateful if you could circle the statement that applies to you:

Never smoked tobacco Ex-smoker Current smoker

If you are a current smoker who wishes assistance to stop smoking please ask for a leaflet at reception, or book an appointment for the smoking cessation clinic. If you prefer, the local pharmacies can also provide information/assistance with smoking cessation.

DRUG NAME/STRENGTH	DIRECTIONS

IF YOU WOULD LIKE TO NOMINATE ONE OF THE LOCAL CHEMISTS TO COLLECT THE PRESCRIPTION ON YOUR BEHALF PLEASE CIRCLE BELOW:

DEARS

WELL

IF THE ITEM IS A CONTROLLED DRUG AND YOU WOULD LIKE TO NOMINATE SOMEONE TO COLLECT IT ON YOUR BEHALF PLEASE PROVIDE THEIR NAME AND DATE OF BIRTH BELOW:

NAME _____ **DATE OF BIRTH** _____