GOREY MEDICAL CENTRE

Repeat Prescription Request Form

Name:	**Address:**	
DOB:	**GMS Num:**	
Tel Num:	**GP:**	**CHEMIST:**

Please allow <u>72 HOURS</u> for your request to be processed & sent to your pharmacy

No	Drug Name	Strength	Quantity	Doctors Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

This request form is for ongoing <u>REPEAT PRESCRIPTIONS ONLY</u>. It cannot be used for acute/once-off medication requests.
If you wish to change or alter your medications/s, you must consult with a doctor.