Contact Us:

Tel: 027 50504 Fax: 027-51988

Email: adminteam@marinomedical.ie

REPEAT PRESCRIPTION REQUEST FORM

Please complete, and send this form back to us to request your medication(s). You can post or bring it in person to our receptionist. Allow a minimum of 48 hours for us to check and prepare your prescription for you and remember to take weekends and bank holidays into account.

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

Address: ---------- Medical Card No: ----------

- Write down clearly what medications you require in BLOCK capital letters.
- If in doubt bring your medication packs to reception and our team will be happy to help.
- If you require further medications please continue your list on another request form.

	MEDICATION	STRENGTH	FORM	DOSAGE
E.g.	Name of drug	75mgs	Tablet	1 once daily
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				

- Have you attended the clinic for a medication review in the past 6 months? **Yes / No**
  Patients on repeat medication will be asked to see a doctor or practice nurse to review prescriptions at regular intervals. Please ensure that you book an appropriate appointment to avoid unnecessary delays re further prescriptions.

PHARMACY OF CHOICE; _____

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

Your Signature: _____ **Date: __ / __ / __**

Our practices are consistent with the Medical Council Guidelines and the privacy principles of the Data Protection Acts. http://www.icgp.ie/data. **All details will be strictly confidential**

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