**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 email to our receptionist. Allow a minimum of 24 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 | | | | |

- 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.

**To comply with data privacy legislation, in the event you are unable to collect your prescription in person, please complete the consent form below.**

**I consent to my prescription being collected by: _____**

**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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