

**PRESCRIPTION REQUEST FORM Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LAST CONSULTATION DATE:**

**PAYMENT OF $25 IS REQUIRED AT THE TIME OF ORDERING**

**Please have your request in before close of business on Wednesday.**

**COLLECTION: Scripts are ready for collection from 3.30pm on Thursday.**

**A CONSULTATION IS REQUIRED FOR: Authority (S8) medications, reviews or**

**change of medication, more than three (3) medications requested, DVA**

**patients. A consultation may also be required if diabetic or blood pressure medication is requested and/or you have not seen the doctor in the last 6-12 months.
Patient’s Name: \_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_**

**Contact Number:**

**Residential Address (Not PO Box): \_\_\_\_\_\_\_\_\_**

**Regular Doctor Attended:**

 **Medication Requested Dose/Strength Taken How Often?**

 **\_\_\_\_\_\_\_\_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_ \_\_**

**Allergies:**

**I Consent to receive prescription as E-Script Yes / No**

**Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact number for SMS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***(Office Use Only)* Paid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Staff Initials: \_\_\_\_\_\_\_\_**



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