Repeat Prescription Request Form

Name:_____

Date of Birth:_____ ***Tel :***_____

Address:_____

Sandycove Surgery

Chemist Name _____

Private prescriptions- a fee of €25 applies payable in advance

No surgery collection at this time and please allow a minimum of ONE WEEK

Medication Name	Dosage (mg/mls)	How many taken per day
e.g. Paracetamol	*500mg*	*2 tablets three times a day*

☐ **I confirm that I am ordering the above medication for my own use only**

☐ **I acknowledge that I have agreed to participate in the eScript program and consent to the sharing of my personal data including my mobile phone number with my selected pharmacist**

Patient Signature _____Date _____