**PHGH Doctors Repeat Prescription Request Form**

[**Tel: 020 8209 2400**](http://Tel:%20020%208209%202400)[**www.phgh.co.uk**](http://www.phgh.co.uk/)

**Please allow 72 hours before collection, excluding weekends and bank holidays.**

|  |  |
| --- | --- |
| **Day of Request** | **Prescription ready for collection** |
| Monday | Thursday |
| Tuesday | Friday |
| Wednesday | Monday |
| Thursday | Tuesday |
| Friday | Wednesday |
| Saturday / Sunday (via on-line access) | Thursday |

|  |  |
| --- | --- |
| **Patient name** |  |
| **Address** |  |
| **Date of Birth** |  |
| **Contact number** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Electronic prescribing** | **Y / N** | **Name of Pharmacy** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of drug required** | **Strength** | **Qty** | **If it is not one of your usual repeat medications please state why you are requesting the drug.**  |
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* **Please state why you are requesting the drug if it is not one of your usual repeat medications.**
* **Medication requests will only be accepted by using this form only.**
* **If the medication is from a private specialist consultation you will need to attach suitable information on the diagnosis and clinical letter for the medication to be issued. Please allow 72 hours for this to be processed.**
* **Please supply the latest INR (if not done at PHGH ) for warfarin scripts**

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| **Date of Birth** |  |
| **Contact number** |  |

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| --- | --- | --- | --- |
| **Electronic prescribing** | **Y / N** | **Name of Pharmacy** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of drug required** | **Strength** | **Qty** | **If it is not one of your usual repeat medications please state why you are requesting the drug.**  |
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