**Eyemouth Medical Practice**

**Repeat Prescription Request**

**Patient Details**

|  |  |
| --- | --- |
| **Full name** |  |
| **Date of birth**  |  |
| **Daytime Contact Telephone Number** |  |
| **Postcode of home address** |  |
| **E-mail address (if applicable)** |  |

**Collection**

Please indicate below the location for collection of the prescription. If nothing is marked, prescriptions will be sent by default to Eyemouth pharmacy.

|  |  |  |
| --- | --- | --- |
| **Chirnside Pharmacy** | **Duns Pharmacy** | **Collect prescription from the Medical Practice \*** |
|  |  |  |

\*This option should be selected for use at any other location.

**Medication Request**

Please add each item required into a separate line within the table.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name of medication**  | **Strength / dose of medication** | **Quantity required** |
| **1** |  |  |  |
| **2** |  |  |  |
| **3** |  |  |  |
| **4** |  |  |  |
| **5** |  |  |  |
| **6** |  |  |  |
| **7** |  |  |  |
| **8** |  |  |  |
| **9** |  |  |  |
| **10** |  |  |  |