|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name** | |  | | | | |
| **Address** | |  | | | | |
| **Date of Birth** | | Day | | Month | Year | |
|  | |  |  | |
| **Telephone** | |  | | | | |
| **E-mail** | |  | | | | |
| **Pharmacy** | | Name | |  | | |
|  | | Address | |  | | |
| **Allergies** | | Yes: Please list | | | No | |
|  | | 1 |  | | | |
| **Any recent changes to medication** | | Yes: Please list | | | No | |
| 1 |  | | | |
| 2 |  | | | |
| 3 |  | | | |
|  | | | | | | |
| **Repeat Medications required** | | | | | | |
|  | **Medication** | | | | **Dose** | **Quantity** |
| eg | Panadol | | | | 500mg | 56 |
| **1** |  | | | |  |  |
| **2** |  | | | |  |  |
| **3** |  | | | |  |  |
| **4** |  | | | |  |  |
| **5** |  | | | |  |  |
| **6** |  | | | |  |  |
| **7** |  | | | |  |  |
| **8** |  | | | |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Fee for service** | A repeat prescription for 6 months incurs a charge of €20. This fee covers the administration time involved in preparing it. **Fee must be paid prior to issuing of prescription** | | |
| **Method of payment** |  | | |
| Call surgery to pay by credit card | 01 8339856 | | Give credit card details to staff |
|  |  | | |
| Bank transfer | IBAN | IE46 BOFI 9005 4343 5632 09 | |
|  | BIC | BOFIIE2D | |
|  | Description | Your name and RptRx | |

|  |  |  |
| --- | --- | --- |
| **Consent to text messages** | Yes | No |
| Text messaging is used for communication with you only. We do not use it for marketing. Full practice text messaging policy available on request. | | |
|  | | |
| **Personal Information:** By using this form you will be sending information about yourself across the internet. Whilst every effort is made to keep this information secure, you should be aware that we cannot offer any guarantees of absolute privacy. If this matter concerns you then you should use another method of ordering a repeat prescription such as posting it with a S.A.E or dropping it into our letter box. | | |