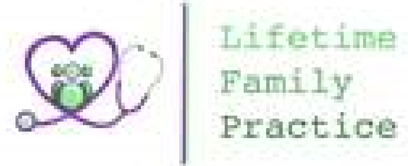
Repeat Prescription form



Patient Name:_________________________ DOB: __ /__ /____

Contact Phone Number: ________________

GP Name - (Please Circle): Dr Lucia Maior / Dr Aisling McGreal / Dr Ariane Gill / Dr John Fitzgerald

Pharmacy for your prescription to be sent to: _________________________

	Medication	**Strength**	**Dose**	**Form**
Eg.	*Asprin*	*75 mg*	*Once daily*	*Tablets*
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

• If you have any difficulty with this form, please ask you pharmacy for assistance.

• Please drop or post this form to the practice (alternatively please request your prescription through our website: http://www.lifetimefamilypractice.ie/prescriptions.html)

• Please allow **2 working days** before collecting your prescription from the pharmacy.

Patient Signature: ____________________ Date: __ /__ /____