Acute Prescription Request

**ACUTE prescriptions** are for items which the GP has decided you can **NOT** order on a regular Repeat prescription. These require longer to process because the GP or Practice Pharmacist needs to review your medical records to determine the appropriateness of the medication you have requested and may take **up to 5 working days** to be ready.

Please complete this form in full and give as much detail. Please note that prescriptions may not be issued or you may need to speak to a Doctor.

Name of Patient:..............................................................................

Date of Birth:....................................................................................

Address:......................................................................................................................................................................................................

Telephone Number (We may need to ring you):...................................

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of medication | Strength | Dose | When did you last have it? | Why do you want it again? |
|  |  |  |  |  |
|  |  |  |  |  |

Please state which Pharmacy you collect your prescriptions from .............................................................................

*Patient or representative please print name, sign and date*

Acute Prescription Request

**ACUTE prescriptions** are for items which the GP has decided you can **NOT** order on a regular Repeat prescription. These require longer to process because the GP or Practice Pharmacist needs to review your medical records to determine the appropriateness of the medication you have requested and may take **up to 5 working days** to be ready.

Please complete this form in full and give as much detail. Please note that prescriptions may not be issued or you may need to speak to a Doctor.

Name of Patient:..............................................................................

Date of Birth:....................................................................................

Address:......................................................................................................................................................................................................

Telephone Number (We may need to ring you):...................................

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of medication | Strength | Dose | When did you last have it? | Why do you want it again? |
|  |  |  |  |  |
|  |  |  |  |  |

Please state which Pharmacy you collect your prescriptions from .............................................................................

*Patient or representative please print name, sign and date*