CASTLE STREET SURGERY

PRESCRIPTION ORDER FORM

Full Name: _____

Address: _____

_____

Date of birth: ___ / ___ / _____ (Day / Month / Year)

Phone: _____ **Email**: _____

Your Doctor: _____

No.	Medication*	Dose*	Quantity*	Frequency*
	e.g. Paracetamol	e.g. 500mg	e.g. 1 tab	e.g. 3 times / day
Drug 1				
Drug 2				
Drug 3				
Drug 4				
Drug 5				
Drug 6				
Drug 7				
Drug 8				
Drug 9				
Drug 10				

NOTES

If you require additional medications, then please continue your list on another request form. If you have any difficulty completing this form, then please ask your pharmacist for assistance. We aim to have all prescription requests reviewed within **2 working days**. Please do not attend the practice to collect your prescription before this.

Please return the completed form to us by hand, post or via email to prescriptions@cssdoctor.ie. Alternatively, you can complete our online Prescription Order Form at www.cssdoctor.ie/prescriptions.

I confirm my request for all of the above medications be re-prescribed for my personal use.

Patient Signature: _____ **Date**: ___ / ___ / _____ (Day / Month / Year)