

PRESCRIPTION REQUEST FORM

PLEASE FILL YOUR PRESCRIPTION FORM

(We aim to have all prescription requests ready within 4 working days.)

NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

USUAL CHEMIST: _____

MEDICAL CARD NO: _____

PHONE NUMBER: _____

Item	Medication Name	Dose	Frequency
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			

REASON PRESCRIPTION MAY NOT BE DONE BY DOCTOR:

You can:

Prescription Request Forms can be delivered to the Surgery by the following means:

1. Deliver this form to the surgery during opening hours 8-1/2-5 MON-FRI
2. Post – please post to Prescriptions The Cremore Clinic 66 Ballygall Road East Dublin 11
3. Fax – please fax to 01-8640255
4. Email to orderscript.cremore@gmail.com