Repeat Prescription Request

Whitemill Medical Centre

Name	**Date of Birth**
Address 	**EIRCODE** ☎
GMS Number if Applicable	
Pharmacy	

	Name of Drug	**Strength**	**Form**	**Dosage**
e.g.	Aspirin	75mg	Tablet	One daily
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Email to **prescription@whitemillmedicalcentre.com**

Your prescription will be sent to your nominated pharmacy within 2 working days by secure Healthmail.

Ensure you have nominated a pharmacy of your choice where your medication can be collected.

Have you attended the surgery for a medication review in the past 6 months Yes ☐ No ☐

Declaration: I confirm that all the requested medication is for my own use ☐

Repeat Prescription Request

Whitemill Medical Centre

Please complete this page if necessary

	Name of Drug	**Strength**	**Form**	**Dosage**
e.g.	Aspirin	75mg	Tablet	One daily
11.				
12.				
13.				
14.				
15.				
16.				
17.				
18.				
19.				
20.				

Please note that interval medication reviews and routine tests (e.g. blood tests/ECG/

24-Hour Blood Pressure Monitor) are required for the prescribing of all long-term medication. The frequency of these tests will depend on your medical problem.

To get the most from your medication review with your doctor please ensure that any investigations have been completed in the weeks prior to your visit. It is also useful to bring your medication with you to your visit.

Please read the data sheet that accompanies your medication.

Remember that your doctor and pharmacist are available to discuss any queries you have in relation to your medication.

Appointments: ☎ 053 914 0000