The Albany Practice
Repeat Prescription Request Form

Full Name:

Address:

Contact number: DoB:

Usual Doctor in case of query:

Date of request:

Attach Ticked Repeat list or List Items required below and over the page if needed		**Supply for Months**
1.		
2.		
3.		
4.		
5.		
6.		

I want the completed prescription to be:

Collected from reception ☐

Sent to **Chemist**. *Wherever possible this will be sent electronically* ☐

Give Chemist's name: ……

Returned by post; stamped addressed envelope included ☐

For reception messages to prescribing doctor……

……

Message for patient from doctor……

When completing this form, please:

- ✓ **Allow two working days for your prescription to be processed. If there are queries or you are overdue for a medication review, it may take**
- ✓ Complete all parts of the form so that you receive the correct prescription and it goes to the correct place**. Without all this information we may not be able to process your prescription.**
- ✓ Write clearly.
- ✓ Tell us which medications you need and how long the supply should last for.
- ✓ Bring the completed form to reception **OR** send it by post to The Albany Practice Brentford Health Centre Boston Manor Road TW8 8DS OR email to HOUCCG.albany@nhs.net
- ✓ If posting allow extra time for processing