

Repeat Prescription Request Form

First Name	Surname	Date of Birth
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Address

I would like to collect my prescription from:

- Surgery
- Sainsbury's
- Village (Farnborough)
- Village (Crofton)
- Apothecare
- Boots (Orpington)

Drug Name	Number and frequency e.g. 2 tabs 3 times a day	Total number required*
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Condition for which drug is required if not issued as a regular repeat prescription or if last issued over a year ago.
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The white, right hand side of your prescription, lists all of your repeat medications. Please retain it and use it to make your next request. Please allow at least 3 working days before collecting your prescription.
* Maximum 8 week supply.

Daytime Contact Telephone Number

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