Please use this form to request medication NOT on your repeat prescription OR for variations to your normal repeat script

Please fill out all sections or we cannot process your request.

This will take three working days

Name:	
Date of Birth:	
Date and day of this request:	
If this is urgent, please say why:	
What is the best number to phone you on if the doctor needs more information?	
What is the name of the Medication that you are requesting?	
What symptoms or disease are you trying to relieve? (If pain, what is the site of the pain?)	
Roughly when did you last have this?	
Roughly how many times have you had this before?	
Which doctor prescribed this for you previously?	
Why do you need this?	(*tick which one applies*)
The symptom/disease has recurred	☐
I was started on this by my doctor to see whether it was effective	☐
It was recommended by another doctor (please specify who)	☐
Other reason for wanting this medication?	
If you think this should be on repeat prescription please say why?	

Variations to Repeat Script PLEASE ATTACH REPEAT SCRIPT SLIP

	Please give further details
The dosage of an item needs changing	
The quantity should be changed	
I have lost my script or some tablets	
Other request	