

Royal Docks Medical Practice

Prescription Order Form

PATIENT NAME

DoB

ADDRESS

TELEPHONE

MEDICATION

PLEASE WRITE A FULL DESCRIPTION OF THE MEDICATION YOU REQUIRE

PROCESSED BY (INIT)

DATE

IMPORTANT – PLEASE NOTE

1. Please allow at least **two working days** before collecting.
2. It is much quicker to use the **repeat order form** if possible.
3. The doctor may ask to see you **before** prescribing.