PALFREY HEALTH CENTRE
REPEAT PRESCRIPTIONS FORM

Please allow for **2 working days** for us to deal with your request.

Please place the request form in the **prescription box** at reception.

Patient Name		
Address		
Date of Birth		
Home Telephone		
	Item Description	**Dose**
Item 1		
Item 2		
Item 3		
Item 4		
Item 5		
Item 6		
Additional Information		

WHICH PHARMACY WOULD YOU LIKE YOUR

PRESCRIPTION SENT TO…….

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