**Deansgrange Medical Centre**

**REPEAT PRESCRIPTION ORDER FORM**

You can also use this form to renew your prescription. We require **one week** notice to prepare your prescription. You can return the form to us by the following methods:

* *Email* it to us at: info@deansgrangemedical.ie
* *Drop* this form into our post box at the upstairs entrance to the surgery.
* *Post* it to: Deansgrange Medical Centre, 2, Clonkeen Road, Blackrock, Co. Dublin.

**Thank you for your co-operation.**

 **YOUR PHARMACY NAME *DATE NEXT PRESCRIPTION DUE***

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| **NAME** |  |
| **DATE OF BIRTH** |  |
| **MEDICAL CARD NUMBER** |  |
| **Email ADDRESS** |  |
| **SIGNATURE** |  |

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| --- | --- | --- | --- | --- |
| **DRUG NAME** | **DOSE** | **QUANTITY REQUIRED PER DAY/MONTH** | **DURATION****1, 3 or 6 MONTHS** | **MEDICATION DISCONTINUED** |
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