PRESCRIPTION REQUEST FORM

Please allow 2 working days for your request to be processed

3 Charleston Rd, Ranelagh, Dublin 6
tel: 01 4975666 **fax:** 01 4975660
www.belgraveclinic.com

PLEASE TICK ONE OF THE FOLLOWING OPTIONS

- ☐ I WILL CALL TO COLLECT MY PRESCRIPTION
- ☐ PLEASE POST MY PRESCRIPTION – (PLEASE SUPPLY A STAMPED ADDRESSED ENVELOPE)
- ☐ MY PHARMACY WILL COLLECT MY PRESCRIPTION

Name:___________________________

Address: _________________________

Pharmacy **Bourke's Rathmines:** ☐

Lloyds:☐ **Burkes Ranelagh** : ☐

Dunville pharmacy:☐ **Leech Pharmacy** : ☐

1. Drug Name:___________________________ One Month ☐ Three Months ☐
2. Drug Name:___________________________ One Month ☐ Three Months ☐
3. Drug Name:___________________________ One Month ☐ Three Months ☐
4. Drug Name:___________________________ One Month ☐ Three Months ☐
5. Drug Name:___________________________ One Month ☐ Three Months ☐
6. Drug Name:___________________________ One Month ☐ Three Months ☐
7. Drug Name:___________________________ One Month ☐ Three Months ☐
8. Drug Name:___________________________ One Month ☐ Three Months ☐
9. Drug Name:___________________________ One Month ☐ Three Months ☐

Comment

Signature: _________________ **Date:** ________________

Dr Brendan Clune, Dr Conor Ryan, Dr Andrea Kelly, Dr Orla de Faoite & Prof Tom Fahey