prescription management consent form

Please complete the details listed below in block capitals.

Title: Mr ☐ Mrs ☐ Miss ☐ Ms ☐ (please tick) Other ☐

First Name: _____ Surname: _____

Address: _____

_____

Postcode: _____ DOB: _____

Home Tel: _____ Mobile: _____

Email: _____

Do you normally collect?: ☐

Doctor: _____

Surgery Address: _____

_____

Postcode: _____ Tel: _____

☐ A. Consent to keep repeat slip at pharmacy.

I hereby authorise Malcolm's Pharmacy to keep my repeat slip to order my prescriptions on contact from myself or representative; and collect, either in person or by means of electric transfer, my prescriptions from the surgery shown above on my behalf. I will contact you if I wish to make any changes to this arrangement. I will inform the pharmacist if I am using any over-the-counter remedies, of any dosage changes or if I am prescribed any other medicines either from my GP or through another prescriber. This will allow you to update my medication record and advise me appropriately about my medication.

And / or

☐ B. Consent to collect prescription from GP surgery.

I hereby authorise Malcolm's Pharmacy to collect, either in person or by means of electronic transfer, my prescriptions from the surgery shown above on my behalf. I will contact you if I wish to make any changes to this arrangement.

Signed: _____ Date: _____

malcolm's pharmacy
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Urmston, Manchester
M41 5AA

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fax: 0161 747 7855
email: info@malcolmspharmacy.co.uk

www.malcolmspharmacy.co.uk

malcolm's
YOUR LOCAL PHARMACY