

Regular Repeat Prescription Request

****Only for medication that is already on a regular repeat list ****

Name:	
Address:	
Postcode:	
Date of birth:	
Telephone number:	
Repeat medication:	
Which Doctor prescribed your medication originally?	
When was it last prescribed?	
Date ordering:	

Either take this form into the surgery reception or email it to tyrfelinsurgery@wales.nhs.uk

**** Please allow 48 hours before collecting ****