



## Record of Patient Consent for Aberlour Pharmacy Staff to Request Repeat Prescriptions and to Collect Prescriptions on Behalf of Patients.

Mr./Mrs./Miss First Name ..... Surname .....

Address.....

.....

.....

Contact telephone no. ....

Date of Birth .....

I would like Aberlour Pharmacy to request repeat prescriptions on my behalf and to pick up my prescriptions from Aberlour Medical Practice and dispense them.

Signed: ..... Date: .....

- I understand that I need to ask the pharmacy to order and / or collect my prescription **every time**. The pharmacy staff need to have your name on their checklist when they collect the prescriptions.
- I understand that I need to tell the pharmacy staff which items on my repeat slip I need. (Not just “everything”!)
- I understand that the pharmacy staff cannot request prescriptions for a different drug name, strength, quantity etc than that on my repeat slip.

Completed forms will be photocopied in pharmacy, original to be filed in Prescription Collection Service file and a copy sent to Aberlour Medical Practice.