**REPEAT DISPENSING SCHEME**

| | |
|---|---|
| | *I would like to receive my prescription via the Repeat Dispensing Scheme and authorise information about my medication being shared with my nominated pharmacy |

| | |
|---|---|
| | *I would NOT like to receive my prescription via the Repeat Dispensing Scheme and request a note be made on my clinical record to reflect this decision |

*Delete as applicable

NAME……………………………………………………………DATE OF BIRTH……………………...............

ADDRESS……………………………………………………………………………………………………………

…………………………………………………………………………………………………………………………….

HOME PHONE NUMBER……………………………………………………………………………………….

MOBILE PHONE NUMBER……………………………………………………………………………………..

NOMINATED PHARMACY TO COLLECT MEDICATION FROM ………………………………………

Please attach to your prescription next time you order or hand in to reception.

Thankyou