REPEAT PRESCRIPTION REQUEST FORM	REPEAT PRESCRIPTION REQUEST FORM	REPEAT PRESCRIPTION REQUEST FORM
NAME:	NAME:	NAME:
DATE of BIRTH:	DATE of BIRTH:	DATE of BIRTH:
ADDRESS:	ADDRESS:	ADDRESS:
TELEPHONE:	TELEPHONE:	TELEPHONE:
MEDICATION REQUIRED:	MEDICATION REQUIRED:	MEDICATION REQUIRED:

PLEASE ALLOW 48 HOURS FOR YOUR PRESCRIPTION TO BE READY FOR COLLECTION (NOT INCLUDING SATURDAY OR SUNDAY)

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