LATYMER ROAD SURGERY – REPEAT PRESCRIPTION REQUEST

PLEASE ALLOW **48 HOURS/2 WORKING DAYS** TO COLLECT YOUR REQUEST

* Must be completed

***Surname:**	***First Name:**	***Telephone No:**
***Date of Birth:**	**Address:**	***Date:**

***Drug Name:**	**Dosage:**

Please use BLOCK CAPITAL letters to complete this form. Failure to do so may result in a delay to your prescription being ready for collection.