MEDICATION REQUEST FORM

Dear Patient

You are requesting a drug/medicine which is not on your repeat medication list.

Please complete the details below to assist the doctor on why you think you need this medication.

Please note: even if you have had this medication in the past the doctor may not necessarily prescribe it again. You may be asked to speak to the doctor or come in for an appointment.

Patient name	
DOB	
Name of Medication	
Reason for request *(Please give as much detail as you can)*	
Date last prescribed *(approx)*	

PRACTICE USE ONLY

Request approved	YES/NO
Add to repeat	YES/NO
To make routine appointment to see	NURSE/DOCTOR