MENTAL HEALTH MEDICATION REQUEST

- Name:
- DOB:
- Address:
- Name of Medication:-
- Dose of medication:-
- How much medication do you have left after todays dose?
- How often do you take (please circle) Once a day   Twice a day
- Quantity of last issue (Please circle)   1 month   2 months   3 months
- Do you want dose increased/ decreased/medication changed (please circle request)
- Routine GP review (Please circle)   Yes   No
- Name and address of Pharmacy:

Date: Sign:

Please return this form to reception or email to hiowicb-p.unicity-prescriptions@nhs.net

PLEASE ALLOW **48 WORKING HOURS** TO PROCESS YOUR REQUEST FROM THE DATE OF REQUEST.
IF YOU HAVE HANDED IN YOUR REQUEST ON A FRIDAY, THEY WILL NOT BE READY UNTIL TUESDAY (PM).
PLEASE TAKE INTO ACCOUNT WEEKENDS AND BANK HOLIDAYS.

****IF REQUESTING OTHER MEDICATION, PLEASE FILL OUT A REPEAT PRESCRIPTION REQUEST FORM****