ADRIAN THOMAS
FFERYLLFA PHARMACY

Prescription Order Form

Please complete the following form and then return to the Pharmacy.

Patient Information

Title ....

First Name ....

Surname ....

Address ....

....

Town/City ....

Postcode ....

Phone ....

Email ....

Date of Birth ....

NHS Number *(optional)* ....

Doctors Surgery ....

Surgery Address ....

....

....

Prescription Medications Required

Medication Name	Strength	Quantity

Collection & Delivery

Your medication can be collected in store from Adrian Thomas Pharmacy or delivered to the patients address. Please indicate your preference below:

☐ I will collect my prescription from Adrian Thomas Pharmacy

☐ Please deliver to the patient address above

Please note that Professional Pharmacy guidance rules **requires someone over the age of 18 to sign for any medicines delivered**.

☐ I give permission for Adrian Thomas Pharmacy to receive my prescriptions from my Doctors either by collection, by post or by electronic transfer. I **will** contact the pharmacy if I want to change this arrangement.

Name .... Date ....

Signature ....

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