ADRIAN THOMAS
FFERYLLFA PHARMACY

Repeat Prescription Management Sign up Form

To sign up for our **FREE** Repeat prescription management service, please complete this form and return it to us. We'll take care of everything else:

Patient Information

Title .....
First Name .....
Surname .....
Address ..... Phone .....
..... Email .....
Town/City ..... Date of Birth .....
Postcode .....

NHS Number *(optional)* .....
Doctors Name .....
Surgery Name .....

Delivery & Collection

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

- ☐ Please deliver my prescriptions to the address above
- ☐ I will collect my prescriptions from Adrian Thomas Pharmacy

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 the surgery 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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