# Rathfarnham Medical Centre

4 Glendoher Road, Rathfarnham, Dublin

## Prescription Request Form

**Name**

**Date of Birth**

**Medical Card or Private**

- [ ] Medical Card
- [ ] Private

**Are you currently registered with us**

- [ ] Yes
- [ ] No

**Is this a repeat prescription?**

- [ ] Yes
- [ ] No

**Have you had a medication review in the last 6 months?**

- [ ] Yes
- [ ] No

**Phone Number**

**Email Address**

**Home Address**

**Your Nominated Pharmacy**

Name and location of your nominated pharmacy

**Your Medications**

Enter your medications including volume and quantity. For example - Paracetamol 500mg twice daily.