We send all our prescriptions electronically.

Please nominate a pharmacy that you would like your prescriptions sent to-

Patients Name……………………………………………………………..Patient D.O.B……………………………………………

Pharmacy name…………………………………………………..

Pharmacy Address…………………………………………………………………………………………………..

Patient Signature…………………………………………… Date……………………………………..

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