KARAKA FAMILY HEALTH

# Repeat Prescription Request Form

***Fax: (09) 282 5966***

***Email:*** *info@karakafamilyhealth.co.nz*

Usual GP:

Date of Request: ...../...../.....  [ NHI: ..... ]

*Staff use only*

1. Repeat Prescriptions are only available to:
   - ✓ ENROLLED patients
   - ✓ Patients seen within the last 3 MONTHS and assessed as stable
2. If you wish for your script to be faxed to a pharmacy of your choice, please provide the details below
3. Requests for CONTROLLED or RESTRICTED medications will be vetted as per Ministry of Health Guidelines for appropriate prescribing
4. Scripts which are not collected will be charged a fee of $10.00
5. Incomplete forms will not be accepted
6. If your script is declined, you will be contacted to arrange a booking with your usual GP
7. If your script is approved and completed, you will be contacted

**Name** ..... ..... **Date of Birth** ..... /..... /.....

(Family Name/ Surname) (Given Name/ Christian name)

**Address**..... **Telephone Number**.....

☐ I will collect my script from the practice ☐ Posted to my above listed address

☐ I request for my script to be faxed to: **please note, a **$5.00** additional charge applies for faxed/posted prescriptions*

**Pharmacy** ..... **Pharmacy Fax Number**.....

**Pharmacy Address**.....

**IMPORTANT: To process your request, please answer the following questions**

Have you had a recent hospital admission **or** a specialist in the past three (3) months? **YES** ☐ **NO** ☐

Have you seen your usual GP in the last three (3) months? **YES** ☐ **NO** ☐

In the last three (3) months, have you had any changes to your medication? **YES** ☐ **NO** ☐

| Name of Medication | Dosage amount | Frequency (per day) |
|---|---|---|
| | | |
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| | | |
| | | |

Doctor to complete

Prescription request ☐ Approved ☐ Declined Deferred + Reason .....

Patient to be reviewed by: ☐ Prac. Nurse ☐ Doctor/GP Intervention type .....

Reception to complete

Date Invoiced: Patient Contacted: Y / N Scanned: Y / N

Patient Signature