# Rathfriland Health Centre

## Prescription Collection Registration Form

**GP Practice:** _____

| Patient Details | |
|---|---|
| **Name:** | |
| **Address:** | |
| **Date of Birth:** | |
| **Telephone:** | **Landline**<br>**Mobile** |
| **On-line ordering** | **If you would like to register for on-line ordering please speak to a member of staff** |

**Nominated pharmacy:** _____

I give consent for Rathfriland Health Centre to give all my prescriptions to the above named pharmacy and for this pharmacy to collect prescriptions on my behalf.

**Signature:** _____

**Date:**_____

For office use only

Recorded within GP Records

Date _____ Initials _____


# Rathfriland Health Centre

## Prescription Collection Registration Form

**GP Practice:** _____

| Patient Details | |
|---|---|
| **Name:** | |
| **Address:** | |
| **Date of Birth:** | |
| **Telephone:** | **Landline**<br>**Mobile** |
| **On-line ordering** | **If you would like to register for on-line ordering please speak to a member of staff** |

**Nominated pharmacy:** _____

I give consent for Rathfriland Health Centre to give all my prescriptions to the above named pharmacy and for this pharmacy to collect prescriptions on my behalf.

**Signature:** _____

**Date:**_____

For office use only

Recorded within GP Records

Date _____ Initials _____