PRESCRIPTION REQUEST SLIP			DATE:		
PARKLANDS SURGERY - RUSHDEN					
NAME:		DATE OF BIRTH:			
ADDRESS:		YOUR DOCTOR:			
PHONE NUMBER:					
PLEASE LIST THE ITEMS YOU REQUIRE BELOW:					
1		DOSAGE		QTY	
2		DOSAGE		QTY	
3		DOSAGE		QTY	
4		DOSAGE		QTY	
5		DOSAGE		QTY	
PLEASE ALLOW 7 DAYS FOR REQUEST TO BE PROCESSED BY SURGERY AND PHARMACY					