SCHEDULE 1 Regulation 2

REPEAT DISPENSING FORMS

PART 1

REPEATABLE PRESCRIPTION

Pharmacy Stamp	Age	Title, Forename, Surname & Address
	DoB	
Number of days treatment NB. Ensure dose is stated		

[GP] or [NURSE] or [PHARMACIST](a)
REPEAT DISPENSING
Authorising no. of issues = [example] i2 RA

[TO BE SIGNED BY PRESCRIBER] *[DATE]*

RA

[prescriber's and contractor's name, address and telephone no.]

PCT NAME CODE

(a) One option to be chosen here to reflect the status of the prescriber.

PART 2

BATCH ISSUE

Pharmacy Stamp	Age	Title, Forename, Surname & Address
	DoB	
Number of days treatment NB. Ensure dose is stated		

[GP] or [NURSE] or [PHARMACIST](a) REPEAT DISPENSING	RD

Repeat dispensing: [example] 6 of 12	*[print the date repeats authorised]*	
		[example] 6

	RD
[prescriber's name and contractor's name, address and telephone no.]	
PCT NAME CODE	

(a) One option to be chosen here to reflect the status of the prescriber.