

Status: This is the original version (as it was originally made). This item of legislation is currently only available in its original format.

SCHEDULE 1

Regulation 2

REPEAT DISPENSING FORMS

PART 1

REPEATABLE PRESCRIPTION

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Pharmacy Stamp	Age	Title, Forename, Surname & Address
	DoB	
Number of days treatment. NB. Ensure dose is stated		
[G ¹] or [NURSE] or [PHARMACIST] (a) REPEAT DISPENSING Authorising no. of issues [example] 12		RA
[TO BE SIGNED BY PRESCRIBER]		
[DATE]		
<input type="checkbox"/> <input checked="" type="checkbox"/>	(prescriber's and contractor's name, address and telephone no.)	RA
PCT NAME CODE		

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

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PART 2

BATCH ISSUE

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Pharmacy Status	Age DoB	Title, Forename, Surname & Address	
Number of days treatment. NB. Ensure dose is stated			
GP or [NURSE] or [PHARMACIST](a) REPEAT DISPENSING			RD
Repeat dispensing: [example] 6 of 12		<i>[print the date repeats authorised]</i>	[example] 6
<input type="checkbox"/>			RD
<input checked="" type="checkbox"/>	<i>[prescriber's name and contractor's name, add ex. no. and telephone no.]</i>		
		PCT NAME CODE	

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