

FREE

REPEAT PRESCRIPTION COLLECTION & DELIVERY SERVICE



ONE CALL DOES IT ALL.....

Tollesbury Pharmacy will collect your repeat prescription from your surgery and have it ready for you to collect when YOU want to pick it up.

HOW IT WORKS....

1. Register for the service by completing the authorisation form opposite.
2. Hand in the completed form to Tollesbury Pharmacy.
3. Phone, fax, e-mail, post or simply pop into Tollesbury Pharmacy, whatever you prefer, to order your repeat prescription.
4. Collect your dispensed prescription from Tollesbury Pharmacy when it is convenient for YOU.

ASK ABOUT SCRIPTSERVE A FREE SECURE ONLINE METHOD OF MANAGING YOUR REPEAT PRESCRIPTIONS

Available at www.scriptserve.co.uk, register at Tollesbury Pharmacy.

*Note that we will only deliver medication to you upon your instruction;
please specify when you place your repeat prescription order.*

one call does it all Tel: 01621 860511



Repeat Prescription Collection/Delivery Authorisation Form

Please complete all the details below, please ask a member of staff if you require any help.

SURGERY COPY BLOCK CAPITALS

TITLE (Please Tick)	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Other <input type="checkbox"/>
FIRST NAME	SURNAME				
DATE OF BIRTH					
ADDRESS	POSTCODE				
TELEPHONE					
MOBILE					
DOCTOR' S NAME					
SURGERY ADDRESS					
POSTCODE	TELEPHONE				

I hereby authorise Tollesbury Pharmacy to collect, either in person or by means of electronic transfer, my prescription from the surgery shown above on my behalf and too deliver medication to my work or home if requested to do so. If I wish to change this arrangement, I will inform either party.

Signed _____ Date _____

TOLLESBURY PHARMACY COPY BLOCK CAPITALS

TITLE (Please Tick)	Mr <input type="checkbox"/>	Mrs <input type="checkbox"/>	Miss <input type="checkbox"/>	Ms <input type="checkbox"/>	Other <input type="checkbox"/>
FIRST NAME	SURNAME				
DATE OF BIRTH					
ADDRESS	POSTCODE				
TELEPHONE					
MOBILE					
DOCTOR' S NAME					
SURGERY ADDRESS					
POSTCODE	TELEPHONE				

I hereby authorise Tollesbury Pharmacy to collect, either in person or by means of electronic transfer, my prescription from the surgery shown above on my behalf and too deliver medication to my work or home if requested to do so. If I wish to change this arrangement, I will inform either party.

Signed _____ Date _____

Mychem Ltd (trading as Tollesbury Pharmacy) will hold the information you provide on this form electronically and otherwise for administration purposes and for assessment and analysis to enable us to improve the products and services we offer. We will not disclose any information to third parties.