

PHARMACEUTICAL SERVICES

**PRESCRIPTION FOR URGENT MEDICATION REQUIRED TO KEEP
REGISTERED PRESCRIBERS OF MEMBER OF STAFF ON DUTY**

Rx no:

PATIENT'S NAME:.....

ADDRESS:.....

.....

AGE (if exempt):.....

Rx

**NB. THIS PRESCRIPTION MUST BE SIGNED BY AN OCCUPATIONAL
HEALTH PHYSICIAN OR CONSULTANT WORKING WITHIN THE TRUST.
SELF-PRESCRIBING IS NOT PERMITTED UNDER THIS POLICY.**

CONSULTANTS

SIGNATURE:.....DATE:.....

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CONSULTANTS NAME

(BLOCK CAPITALS):.....

ALL AREAS MUST BE COMPLETED BEFORE DISPENSING

PHARMACY USE ONLY

DATE DISPENSED:.....

DISPENSED BY:..... CHECKED BY:.....

FEE PAID:..... ENTERED IN PRIVATE Rx BOOK: Y/N