Department of
Health, Social Services
and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta
agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

Repeat Dispensing Patient Consent Form

Patient Details	
Name	**Date of Birth**
Address	
Phone	
Please give the name of the pharmacy (chemist) where you normally have your prescriptions dispensed	
Pharmacy Name	

I am the patient named above. My doctor/pharmacist has explained the **Repeat Dispensing** scheme to me. I have also been given a Repeat Dispensing patient information leaflet about this.

I have read, "What the patient needs to know" and I understand how the scheme works and what I have to do.

I agree to get my medicines (or other items) by the **Repeat Dispensing** method and for information on my medication or treatments to be exchanged between my GP and the Pharmacist.

I understand that all information will be handled confidentially and in an anonymised form, and that the HSS Boards and DHSSPS may use information collected from this scheme for the purposes of monitoring and evaluation.

Patient's Signature ______________________________ Date ______________

Practice or Pharmacy Details (where consent was obtained)
Name
Address
Phone

Copies to be retained by the GP practice and the community pharmacy