

# PRIVATE PRESCRIPTION

HOSPITAL NAME AND ADDRESS	PATIENT IDENTIFIER
	INITIALS NHS NUMBER

NAME	DOB

Please dispense the following medication for the above individual who is an in-patient at this establishment according to the following dosage schedule (NB. STRIKE THROUGH UNUSED SECTIONS):

MEDICINE NAME / STRENGTH / FORM	DOSE & FREQUENCY	NO. OF DAYS TREATMENT	OR SPECIFY EXACT QUANTITY FOR PRNs	QUANTITY RECEIVED	RECEIVED BY : SIGN AND DATE

If Lithium is prescribed on this form, please supply the associated Lithium form

MEDICAL SIGNATURE	QUALIFICATIONS	GMC NO
PRINT NAME	DATE	

1. Email encrypted copy to [dispensary@speedshealthcare.co.uk](mailto:dispensary@speedshealthcare.co.uk)
2. Copy this form and retain as evidence of ordering.  
Post off original form immediately, using pre-paid envelopes to: *Speeds Healthcare, One Lakeside, Chester, CH4 9QT*

FAXED BY	DATE & TIME SENT