Dr Eamon Spillane
Dr Sinead O'Callaghan
Dr Caoilfhionn O'Sullivan
Dr Gordon Cantwell

133 St Peter's Rd, Walkinstown, D12 XN9F
Ph 01 4504168 Fax 4783175

23 Old Bawn Way, Tallaght, D24 TKP0
Ph 4504168 Direct line/fax 4511808

LONGTERM MEDICATION REQUEST FORM

PATIENT NAME:____

*****DATE LAST SEEN BY GP***____

ADDRESS____

DOB____

GMS NUMBER____

CONTACT NUMBER____

SIGNATURE__________________________**DATE**__________________________

NAME OF DRUG AND DOSE	NAME OF DRUG AND DOSE
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
11.	12.
13.	14.
15.	16.
17.	18.
19.	20.
21.	22.
23.	24.

WHICH PHARMACY DO YOU ATTEND ______________________________________

DEAR PHARMACIST IN THE EVENT YOU HAVE HELPED COMPLETE THIS PLEASE DATE AND SIGN OR STAMP, MANY THANKS

DATE *SIG* ***DATE LAST SEEN BY GP*	*STAMP*