aL5[!b5{ tI!wa!/¸ PATIENTS PROFILE Chwa

Name:	Date of Birth:
Home Contact Number:	Mobile Contact Number:
E-Mail Address:	
Home Address:	
Delivery Address (if different from Home Address):	

PLEASE TICK IF YOU SUFFER FROM ANY OF THE FOLLOWING CONDITIONS:

Asthma ☐ High/Low Blood pressure ☐ Diabetes ☐ Epilepsy ☐ Heart Condition ☐

CLINICAL PROFILE (Please tick)

The named patient does not take any other medications ☐

The named patient takes other prescription or herbal medication ☐

MEDICATION NAME	STRENGTH(mg)	DOSE (how many times a day you take your medicine)

PAYMENT METHOD:

COMPLETE IF THE PATIENT IS EXEMPT FROM PRESCRIPTION CHARGES (Please tick exemption type below) ☐

The patient doesn't have to pay because he/she:

A is under 16 years of age ☐
B is 16, 17 or 18 and in full-time education ☐
C is 60 years of age or over ☐
D has a valid maternity exemption certificate ☐
E has a valid medical exemption certificate ☐
F has a valid prescription pre-payment certificate ☐
G has a valid War Pension exemption certificate ☐
L is named on a current NHS HC2 charges certificate ☐
X was prescribed free-of-charge contraceptives ☐
H gets, or has a partner who gets Income Support or income-related Allowance ☐
K gets, or has a partner who gets Income based Jobseeker''s Allowance ☐
M is entitled to, or named on, a valid NHS Tax Credit Exemption Certificate ☐
S has a partner who gets Pension Credit guarantee credit (PCGC) ☐

Please make sure to fill the reverse of the prescription and sign to confirm your exemption from prescription charges

PAYMENT METHOD (Please tick):

I PAY FOR MY NHSĸtwL±!¢9 PRESCRIPTION{ ...
(To be confirmed by email prior to ƻŊŘŜŊɏƎǖ

Type of Payment Card	VISA Debit ☐	VISA ☐	Master Card ☐
	Delta ☐	AMEX ☐	PayPal ☐

Card Number: ..../................../................./............./

Name on Card: ....

Start Date: .... Expiry Date .... Issue No:........

Alternatively, you can send a cheque or postal order (made payable to a Pharm UY Ltd) with your order

ORDER TYPE (please tick box):

PHARMACY MED ☐ NHS PRESCRIPTION ☐ PRIVATE PRESCRIPTION ☐ REPEAT DELIVERY ORDER ☐ REPEAT DISPENSING ORDER ☐

Please Fax or Email a copy of the completed form with a copy of the prescription to:

Fax: лммр ÈÈÈÈÈÈÈ or Email: ǈŊŜǎŎŊǈǘƻɣãƳƳƛŘƖƖƴŘǈƘƖŊƳƖŐèǿŐƻƳ

Post the completed form along with your prescription, to:

Midlands Pharmacy, Office 4, Southwold Drive, Nottingham, NG8 1PA

PLEASE NOTE ALL ORIGINAL PRESCRIPTIONS MUST BE POSTED TO THE ABOVE ADDRESS FOLLOWING FAX OR EMAIL

PLEASE ALLOW 5 WORKING DAYS FOR YOUR PRESCRIPTION TO BE DELIVERED FROM THE DATE YOU POST THE PRESCRIPTION TO US. FOR ASSISTANCE PLEASE CALL