



## URGENT PRESCRIPTION REQUEST

Date:

|  |  |
|--|--|
| Patient information  |  |
| Patient name   |  |
| Date of Birth  |  |
| NHS Number   |  |
| <i>Number of previous urgent requests in the past (to be completed by staff)</i> |  |

|                     |
|---------------------|
| Medication Required |
|                     |

|   |
|---|
| Reason for urgent medication  |
|   |
| Please note that if you have lost a controlled drug, the GP may ask for a crime reference number before processing your request |

|  |
|--|
| Acknowledgement of understanding of Repeat Prescribing Policy (see overleaf) |
|  |
| Patient signature  |
|  |
| Date   |

A copy of this form will be scanned on to your medical records. Repeated inappropriate requests may result in future requests being declined and then treated as routine (available after three full working days).

Please hand this form in to reception or scan and email to [thecambridge.practice@nhs.net](mailto:thecambridge.practice@nhs.net)