



Griffith Avenue
Practice

Dr Karen Aylward
Dr Robert Scanlon
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Prescription Renewal Form

Name _____

Date of Birth ___ / ___ / _____

Address _____

Mobile _____

Doctor _____

Medical Card Number (if applicable) _____

Have you visited your doctor for a medication review in the past 12 months? Yes/No _____

Please email* your request to reception@griffithavenuepractice.com , drop it into us or post

Your prescription will be ready for collection in 72 hours (3 working days)

Medication	Strength	Qty taken each dose	Number of times taken per day
e.g. Paracetamol	500mg	2 Tabs	Four times a day
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
NEW CHANGES / REQUESTS			
1.			
2.			

* DO NOT send clinical queries to this email address & please be aware that emails have no guarantee of security

OFFICE USE ONLY

DATE RECEIVED: _____ CHECKED BY: _____ COMMENT/FOLLOW UP _____
