AMCAL AVENUES PHARMACY
www.avenuespharmacy.com.au
FreeCall 1300 131 061 Fax 08 8362 5632

Reply Paid 119
Stepney SA 5069

PRESCRIPTION REGISTRATION FORM

Patient's First Name _____

Surname _____

Address _____

_____

Suburb _____ Postcode _____

Date of Birth _____/_____/_____

Sex F ☐ M ☐

Known Drug Allergies

☐ Aspirin ☐ Codeine ☐ Erythromycin

☐ Penicillin ☐ Sulfur ☐ Tetracycline

☐ Other

Medical Conditions

☐ Arthritis ☐ Asthma ☐ Diabetes

☐ Epilepsy ☐ Thyroid ☐ Stomach Ulcer

☐ Glaucoma ☐ Heart Condition

☐ High Blood Pressure ☐ Other

Entitlement Card No. _____
You may include a photocopy of your Medicare Card or Entitlement Card

Card Type

☐ Pension ☐ Healthcare ☐ Veterans

☐ Safety Net

Medicare Number

Expiry date _____/_____

Medication currently being taken (including non-prescription medication and vitamins)

Name	Strength	Directions

- Would you like a receipt for your private health fund?

Yes ☐ No ☐

- Would you like us to keep your repeat prescriptions?

Yes ☐ No ☐

- If there is a generic less expensive equivalent of your medication and your doctor allows it would you prefer it?

Yes ☐ No ☐

If you are sending prescriptions for more than one person, please fill out an order form for each person.