PHARMACY SELECTION FORM

Name: _____

Date of Birth: _____

Please tell us what you would like us to do with your prescriptions once they have been signed:

Keep them at the surgery for me to collect ☐

Send to the pharmacy (please tick the pharmacy of your choice):

- Boots Fremington ☐
- Boots Roundswell ☐
- Boots High Street Barnstaple ☐
- Sainsbury's Roundswell ☐
- Tesco's Seven Brethren ☐
- Other (please specify pharmacy) ☐

_____

Prescriptions will be sent electronically to your pharmacy unless you specify otherwise