fox PHARMA+

| PATIENT | PRESCRIBER |
|---|---|
| DATE: | NAME: |
| NAME: | QUALIFICATION: |
| ADDRESS: | GMC/GDC/GPHC/PIN NO. |
| | CLINIC ADDRESS: |
| POSTCODE: | |
| TELEPHONE: | TELEPHONE: |
| DATE OF BIRTH: | ORDER NUMBER: |
| DATE FACE-TO-FACE CONSULTATION OCCURED: | |

## PRESCRIPTION ITEMS

| QUANTITY | DESCRIPTION | PACK SIZE | DIRECTIONS |
|---|---|---|---|
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PRESCRIBERS SIGNATURE:

By using this prescribing tool you are agreeing to all of FoxPharma terms and conditions you also take full clinical responsibility for anything you prescribe for your patients.

Any prescriptions you send via email i.e. a scanned in upload of your own prescriptions, it is a legal requirement that you send the original to us within 72hrs.