# BETHESDA MEDICAL CENTRE

Palm Bay Avenue, Cliftonville, Margate, Kent, CT9 3NR
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## REPEAT MEDICATION REQUEST FORM

| | | | |
|---|---|---|---|
| **Surname:** | | | |
| **Forename:** | | | |
| **Date of Birth:** | / / | **Today's Date:** | / / |
| **Postcode:** | | **Pharmacy:** | |

| Medication | Dosage | Per Day | Supply |
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PLEASE ALLOW A MINIMUM OF **3 FULL DAYS** (72 HOURS) FOR YOUR MEDICATION REQUEST TO BE PROCESSED. THANK YOU.