

Kingswood Compounding Pharmacy

Prescription Order Form

PERSONAL/PATIENT DETAILS		
Title _____	First Name _____	Last Name _____
D.O.B _____	Weight (kg) _____	
Postal Address _____		
_____ State _____		Postcode _____
Home Ph. _____	Mobile _____	
Email _____		
<input type="checkbox"/> Existing Customer	<input type="checkbox"/> New Customer	

PAYMENT DETAILS		
<input type="checkbox"/> I will pay upon collection from pharmacy		
<input type="checkbox"/> please charge my credit card and send to my postal address		
<input type="checkbox"/> Visa	<input type="checkbox"/> MasterCard	
Credit Card No. _____/_____/_____/_____	Expiry _____/_____	
Cardholders Name _____		
Signature _____		Date _____

CHOOSE YOUR FLAVOUR – If ordering TROCHE or MIXTURE		
<input type="checkbox"/> Banana <input type="checkbox"/> Strawberry / Colour Free Strawberry <input type="checkbox"/> Chocolate <input type="checkbox"/> Grape / Colour Free Grape <input type="checkbox"/> Vanilla		
<input type="checkbox"/> Bubble Gum <input type="checkbox"/> Apple <input type="checkbox"/> Cotton Candy <input type="checkbox"/> Peppermint <input type="checkbox"/> Raspberry <input type="checkbox"/> Butterscotch <input type="checkbox"/> Marshmallow		
<input type="checkbox"/> Watermelon <input type="checkbox"/> Orange <input type="checkbox"/> Tangerine <input type="checkbox"/> Tutti Frutti		

PREFERRED PACKAGING – If ordering CREAM	
<input type="checkbox"/> EMP Jar	<input type="checkbox"/> Dosing Pump

SPECIAL INSTRUCTIONS/REQUESTS

Please note that prescriptions may be faxed to us so that we can start compounding your medication and save you time. However by law, original script must be sent to our postal address. Repeat prescriptions will be stored in your file and can be ordered anytime by phone, fax or email. The label on your medication will indicate the number of repeats left on your prescription.

Phone (02) 4721 2752

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Fax (02) 4721 2312

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