



Weleda Pharmacy Limited

## REQUEST FOR COMPOUNDED MEDICINES

Fax to 06 877 3128 or scan & email to [dispensary@weledapharmacy.co.nz](mailto:dispensary@weledapharmacy.co.nz)

Requesting Clinic Name: \_\_\_\_\_

Delivery Address (not PO Box)	Phone:	
	Email:	
	Fax:	
Postcode:	OR	Account Code (if charge account):
Payment: Credit Card Details		
Number:		
Expiry:		
Name on Card:		
Medicine	Patient Name	Quantity Required

### Conditions of Supply

1. Compounded prescription medicines will be supplied by Weleda Pharmacy Limited under Regulation 44 of the Medicines Regulations 1984.
2. The requesting Doctor is responsible for their own record keeping and reporting requirements.
3. The requesting Doctor is responsible for packaging, labelling and counselling to the patient.

I hereby request Weleda Pharmacy Ltd to compound the medicines listed, for these patients under my care.

Requesting Doctor's name: \_\_\_\_\_ Registration Number \_\_\_\_\_

Doctor's signature: \_\_\_\_\_ Date: \_\_\_\_\_