WELEDA PHARMACY

REQUEST FOR COMPOUNDED MEDICINES

Fax to 09 888 2110 or scan & email to pharmacist@weledapharmacy.co.nz

Requesting Clinic Name: _____

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

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: _____

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