WELEDA PHARMACY

REQUEST FOR COMPOUNDED MEDICINES

Form & Prescription: Fax 09 888 2110 OR scan/email: pharmacist@weledapharmacy.co.nz

Requesting Pharmacy 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**	**Dispensing Qty Req'd**	
		Stat(all); 1st disp	**Repeat Rx No**

Conditions of Supply

1. Compounded medicines will be supplied by Weleda Pharmacy Limited under Regulation 44 of the Medicines Regulations 1984 and section 26(3) (a) of the Medicines Act 1981.
2. A copy of the prescription must be faxed for each medicine requested. We do NOT require the original.
3. The requesting Pharmacy is responsible for their own record keeping and reporting requirements.
4. The requesting Pharmacy is responsible for counselling the patient.

I hereby request Weleda Pharmacy Ltd to compound the medicines listed, for which I hold a valid original prescription.

Requesting Pharmacist's name: ____

Pharmacist's signature:________________________________

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