

PHARMACEUTICAL SERVICES ORDER FORM

All sections of this form are mandatory. Failure to complete any part of the form may result in non-fulfilment of your script or a later delivery date.

This form is intended to be used in conjunction with the Department of Parliamentary Services Pharmaceutical Services Policy.

Do you consent to the Department of Parliamentary Services collecting the personal information included on this form to allow the Nurses Centre to contact you once your prescription is available to be picked up?

Yes - Please email this form, along with the prescription, to barton@brandspharmacy.com.au and include nursescentre@aph.gov.au as a CC.

No - Please email this form, along with the prescription, to barton@brandspharmacy.com.au.

SECTION 1 - YOUR DETAILS

Full Name:	Date of Birth:
Email:	Phone Number*:
Address:	
State:	Post Code: Office/Suite #

*The Pharmacy may need to contact you prior to dispensing your script. Please ensure you available to speak to the Pharmacists if required.

Medicare Card Number: _____

Concession Card: Yes (If yes, please provide number below) No

Close the Gap Eligibility: Yes (If yes, please provide number below) No

Private Health Fund: Yes (If yes, please provide details below) No

SECTION 2 - PRESCRIPTION DETAILS

Item/s to be dispensed: _____

Preference for generic medicine: Yes No

Any known Allergies? Yes (If yes, please provide details below) No

Other health conditions? Yes (If yes, please provide details below) No

SECTION 3 - PAYMENT DETAILS

Credit/Debit Card Type: Master Card Visa Other

Credit/Debit Card Number:

Expiry Date:

Security Code*:

*Security Code is the 3 digit number on the back of your credit/debit card

Card Holder Name: _____

Card Holder Signature: _____

SECTION 3 - AUTHORISATION

If you would like to nominate a person to act on your behalf, including receiving calls from the Pharmacist and facilitating payment arrangements, please complete the below information.

Your Authorised Person's name: _____

Your Authorised Person's contact number: _____

Please note that this checklist will be required each time a prescription is dispensed and does not form a standing arrangement.

Your Signature: _____

Date: