

REQUEST FOR COMPOUNDED MEDICINES



COMPLETE and FAX to: (09) 442 5851

Scripts MUST be faxed with this form to avoid delays.

Date: _____ Contact phone number: _____

Requesting Pharmacy Name: _____

Delivery Address : _____

Medicine (including dose form & dose strength)	Patient name	Quantity Required (circle one option)
		Initial 1 st Rpt 2 nd Rpt All
		Initial 1 st Rpt 2 nd Rpt All
		Initial 1 st Rpt 2 nd Rpt All
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Conditions of Supply

1. Compounded prescription, restricted and pharmacy only medicines will be supplied by PCNZ 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 packaging, labelling, and counselling to the patient.
4. The requesting Pharmacy is responsible for their own record keeping and reporting requirements.

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

Requesting Pharmacist's name: _____ Pharmacist's signature: _____

Request Form - Pharmacy Version: 09 2008

Please note that our telephone numbers have changed, however our other contact details remain the same.

62C Diana Drive, Glenfield, North Shore 0627, P.O. Box 101 142 North Shore Mail Centre 0745, Auckland NZ
Direct line to Customer Services: (09) 442 1728 General Enquiries (09) 442 1727
 email: info@pharmaceutical.co.nz