

PATIENT NAME: _____ DATE OF BIRTH: ____/____/____
PATIENT'S RESIDENTIAL ADDRESS: _____

TELEPHONE	POSTCODE
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- I am fully aware of and accept clinical, professional and legal responsibility for prescribing outside the recommendations of any of the product's products, whenever applicable
- A face-to-face consultation with this patient has been completed
- When I have considered it appropriate for another practitioner to administer the prescription to my patient, under my direction, the named practitioner has been trained and I remain the usual practitioner to be contacted
- The named patient is responsible for the cost of the prescription and has consented for it to be delivered to the patient's agent named at the address provided

Weeks (Days 1-3) _____ Days _____

PROCESSED BY: _____

PROCESSED BY: _____

POLYMER LETTERS

PROCESSED BY: _____

PROSECUTOR'S SIGNATURE: _____ DATE: _____