

PRIMARY CARE DISTRIBUTION CENTRE  
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## **PHARMACIST GP10P PRESCRIPTION PADS ORDER FORM**

PHARMACIST'S NAME: \_\_\_\_\_

GPhC REGISTRATION: \_\_\_\_\_

PRESCRIBER CODE: \_\_\_\_\_

ADDRESS: (Delivery of prescription forms)

_____	<input type="checkbox"/> Main Practice
_____	<input type="checkbox"/> Additional Practice
_____	<input type="checkbox"/> HSCP

QUALIFICATION: ☐ Supplementary Pharmacist Prescriber

☐ Independent Pharmacist Prescriber

<p><b>Please supply prescription pads GP10P(5) (4 pads)</b> Orders for this must be placed by 5pm on the second Tuesday of the month. Orders will be delivered within 6 weeks of the order being placed.</p>	
<p><b>Please supply Common Clinical Conditions pads (4 pads)</b> Orders for this must be placed by 5pm on the second Tuesday of the month. Orders will be delivered within 6 weeks of the order being placed.</p>	

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

\*Please fill out all parts of the order form and tick where appropriate\*