



COMPOUNDING ORDER - PHARMACY

FIRST NAME: _____ SURNAME: _____

MOBILE: _____ EMAIL: _____

ALLERGIES: _____ DATE OF BIRTH: __/__/____

DATE: _____

NUMBER OF COMPOUNDING ITEM(S) REQUIRED:

Please fill out the following information as seen on the prescription.

ITEM 1

Product Name: _____ Strength: _____
Quantity: _____ Repeats: _____

ITEM 2

Product Name: _____ Strength: _____
Quantity: _____ Repeats: _____

ITEM 3

Product Name: _____ Strength: _____
Quantity: _____ Repeats: _____

FLAVOUR (If necessary):

ORDERING CHECKLIST:

Script is being faxed to 07 5530 6677 or email to admin@customcompounding.com.au
Script has been attached to this document
Script is being posted (free postage):

National Custom Compounding
Reply Paid 86714
MERRIMAC QLD 4226

**All repeat prescriptions will be kept on file for reordering.*

**If you would like repeats returned, please attach a note to original prescription(s) when posting.*

NOTES: _____

URGENCY OF ORDER: **LOW** Ready in 3 to 5 Days
NORMAL Ready in 1 to 2 Days
URGENT Ready within 24 Hours*

Pharmacy Details

Once form is completed please select **Send (below)** or Fax to **0755306677**