PSD 6 CDRF Order Form

CONTROLLED DRUG REQUISITION FORM

THIS ORDER MUST BE APPROVED BY THE HEALTH BOARD

SECTION 1: TO BE COMPLETED BY PRESCRIBER

Prescriber Details

Profession **GP** ☐ **Nurse** ☐ **Pharmacist** ☐ **Dentist** ☐

Other (Please state) ☐

Prescriber Code ☐

SURNAME: ………..………………… **INITIALS**: …........………

Address to be printed on pads:

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………………........................…………………………………………

………………………………....................…………………………

Post Code…………………………….

Contact Telephone Number: ....……………………………

NO OF PADS (Minimum 1) ☐

WHEN SECTION ONE IS COMPLETED PLEASE PASS TO HEALTH BOARD

SECTION 2: FOR HEALTH BOARD USE ONLY. Please return to:

Practitioner and Counter Fraud Services, 3 Bain Square, Livingston, EH54 7DQ
Tel: 01506 705100 Fax: 01506 705191 Email: NSS.psd-pscriber-statnry@nhs.net

Approved address for delivery of pads:

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Post Code: ………………………...

Health Board ☐

Health Board Order Number ☐

Signed: ……………....…………………………… **Authorised Signatory** **Date:** ……….............…………

Print Name: …………………………….........…… **Telephone Number:** ……………………………..