PRIVATE PRESCRIPTION

AESTHETICA SOLUTIONS

After undertaking a face-to-face consultation for:

PATIENT NAME:	DATE OF BIRTH:
PATIENT'S RESIDENTIAL ADDRESS: POST CODE:	
DATE:	

ACCOUNT HOLDER NAME:	

PRODUCT	**PACK SIZE**	**QUANTITY**
SPECIAL REQUIREMENTS:		

I confirm that, as the prescriber:

I am fully aware of and accept clinical, professional and legal responsibility for prescribing outside the licensed indications of any of the prescribed products, wherever applicable

A face-to-face consultation with the patient has been done

When I have considered it appropriate for another practitioner to administer this prescription to my patient under my direction, the named practitioner has been trained and I consider the said practitioner to be competent

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.

The medication's (i.e. toxin's) Prescribed is for the sole use of/on the Patient mentioned above and any outstanding vials must be thrown away as appropriate and not be re-used for another.

I hereby agree to adhere to all Aesthetica Solutions Ltd's Terms and conditions available on the website and also agree to the rules set out by the regulatory bodies such as GPHC, MHRA, HMRC and all other relevant regulatory bodies associated with my practice.

PRESCRIBER'S NAME:		PRESCRIBER'S REG. NO:
PRESCRIBER'S ADDRESS: POST CODE:		
PRESCRIBER'S TEL:	PRESCRIBER'S PROFESSION:	PRESCRIPBER'S SIGNATURE:

Please note: It is legal requirement that the original prescriptions must be sent to the pharmacy within 72 hours.