PCH Pharmacy Medication Pre-Order Form

Please complete the following details below and email it as an attachment, along with a photo/scan of both copies of all prescriptions (patient or pharmacist copy and repeat form), to pch.pharmacydispensary@health.wa.gov.au.

1. Child's Details	
Full Name	
UMRN (if known)	
Date of Birth	Please record the date of birth like this: 01/02/2026 (day/month/year)
Current Weight (kg)	
Allergies	- Select Yes or No - If yes, please list your child's allergy/allergies

2. Contact Details			
Parent/ Guardian Name			
Phone Number		**Email**	

3. Medication(s) Required			
Medication Name	**Current Dose**	**Number of Months Required** **(maximum of one-month PBS and up to three months non-PBS)**	**Comments** New? Recent Change?
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	
		- Select number of months required -	

4. Preferred Collection Details	
Date Required By	Please record the required by date like this: 01/02/2026 (day/month/year)
Please tick ☑ <u>one</u> of the following options:	☐ Collection at PCH Outpatient Pharmacy ☐ Deliver to address:

Checklist

☐ Attach a photo/scan of both copies of the prescriptions required for each medication and Pre-Order Form to email

☐ **Bring in the original prescriptions to the pharmacy upon collection OR post in original prescriptions**