

Controlled Drug Collection Authorisation (New Zealand)

Patient Details

Full Name:

Date of Birth:

Address:

NHI Number (if known):

Medication Details

Name of Controlled Drug:

Prescription Date:

Prescribing Doctor:

Authorised Collector Details

Full Name:

Deen Cody Tigerland

Date of Birth:

11-11-83

Relationship to Patient:

Courier

Address:

32 Withells Road, Avonhead, Christchurch

Phone Number:

0225930496

Photo ID Type & Number:

Company ID 111183

Authorisation Statement

I, _____ (patient name), authorise the person named above to collect my prescribed controlled medication on my behalf from the pharmacy listed below. I understand that: - The authorised person must present valid photo identification at the time of collection. - The pharmacy may refuse supply if legal requirements are not met. - This authorisation applies only to the medication specified above unless otherwise agreed with the pharmacy.

Pharmacy Name:

Patient Signature:

Date:

Pharmacy Use Only (Audit Record)

Collected By (name):

ID Verified (type/last 4 digits):

Quantity Supplied:

Pharmacist Name & Signature:

Date of Collection:
