

## Femily Wellness Hospital

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Name of Patient/Dep. Name:

## **MEDICINE RETURN SLIP**

PRN: Consultant:		Ward/ Bed No:				
				Date:		
Sr. No.	Name of Medicine	Strenght	Qty. Rtnd	Qty Receive	Packed By	Remark
31. NO.	Name of Medicine	Strengitt	Qty. Ktilu	Qty Neceive	Packed by	Nemark
Returned By					Received By	
					Date & Time	
Returened By						
Name		Head of Departmen	t	Authorised By		