Gilead Medical & Dental Centre

PRESCRIPTION FORM

Date: dd / mm / yyyy

Patient's Full Name

Address | Gender ☐ M ☐ F | Age

Rx Approved / Generic Name of Medication (Additionally, Indicated trade name only if therapeutically appropriate)	ROUTE	DOSE (eg. mg. ml. microgram, etc)	DOSE REGIME (once daily/ od, Twice daily/ bd, 8-hrly/tds, etc)	Total No. of Tablets/ Drugs	No. of Days
1					
2					
3					
4					
5					
6					
7					
8					

Please cross out all unused spaces for medications above and complete all spaces below.

Prescriber's Name & Designation

Prescriber's Phone No.

Signature & Stamp

Date: dd / mm / yyyy

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