

# ACCRA MEDICAL CENTRE



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## PRESCRIPTION FORM

Name: Steve Lower Wodo DOB: 11/04/1975  
Date: 01/11/17 Address: .....

R<sub>x</sub> ① Inhaler ~~Symbicort 160/4.5ug~~  
R<sub>x</sub> ~~OD x 30/7~~

**ACCRA MEDICAL CENTRE**  
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Kumapley  
Doctor's Name & Signature

Date: 01/11/17

Alternative equivalent

Dispense as written

Repeat

1

2

Time